Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Year Month 935 **Physician** PM Oundacks December 1004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Baltrucons Baltimore city 1 WIVEVSITY 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours Months 1 □ M 287ME 174-82-0271 6 Jun 15. 2004 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 √Yes 2 No Director PA Franklin Waynesboro 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 23a or 17268 558 S. Church Street USA by Funeral filed within 72 hours after death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 6 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a othar treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 is marked other. Kimberley E. Moore Wesley M. Gundacker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 is
any injury or othar treu
once. 558 S. Church St. Waynesboro, PA 17268 Wesley M. Gundacker father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 XRemoval from State Dec 21, 2004 Fairfield, PA \* 4 □ Donation 5 □ Other (Specify) Fountaindale Union 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc 21. Signature of Funeral Service Licensee Mmen Lanette 50 S. Broad St., Waynesboro, PA 17268 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TUNG disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit 0 M (0 (W resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the al Records, P.O. Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA P After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 🗌 Yes 2 | No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD

ORIGINAL

Green Street Balfimenz

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** STORE xecember 13, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Way End Moderal Cake Batting (If Under 24 Hrs imare ( 2011Ersid 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jun 15, 2004 Birthplace (State or Foreign Country) **Funeral** Months 5 Days 27 1 M 2 1 F Hours Jun MD Director 174-82-0272 Usual Residence of Decedent 10a State 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryien Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumstic avent, the Medical Example must be notified at once. 10d. Inside City Limits 10h County Franklin Waynesboro 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 558 S. Church Street 17268 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kimberley E. Moore Wesley M. Gundacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley M. Gundacker father 558 S. Church St. Waynesboro, PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☑Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 21, 2004Fairfield, PA Fountaindale Union 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc larette Broad St., Waynesboro, PA 17268 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1 Yes 2 No To the Hospital or Attending Physician: ours after death.

nerel Diractor: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 Ø No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
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completely filled i 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1). 31. Date filed (Month, Day, Year) 23 kar's Signature State JAN 0 4 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 0507AM Dorothy Louise Firey Horchner 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital Hagerstown Year If Under 24 Hr 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗶 F Months Days Hours Yrs. Director 216-14-5172 August 22 1928 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28e-f show the Medical Evantiner must be notified at 1 ☐ Yes 2 No Maryland Washington Directo Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21919 Martin Circle

11. Marital Status

12. Was Decedent Ever in U.S.

Amed Forces? 21.742

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) U.S.A. 14 Race American Indian, Black, White, etc. □Yes 2X No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐Xio Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dr. Thurman C. Firey Sarah H. Kreps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Kyle Horchner (husband) 21919 Martin Circle Hagerstown Maryland 21742 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 Burial 2 Cremation 3 Removal from State ŏ permit. Page Department of Important: If any injury or \* 4 ☐Donation 5 ☐ Other (Specify) Cedar Hill cemetery 12-29-2004 Greencastle Pennsylvani 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a. INTAME = AGARAL HEMOKAHA -5 C DAYS /Medical Due to (or as a consequence of) Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPE ATENSION Due to (or as a consequence of): Examine certificate be executed burial-transit Due to (or as a consequence of): attending physician 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
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Registrar DHMH 17 Rev 1/2001

State

BARRY COHEN, 322

31. Date filed (Month, Day, Year) UEC 27

wenter

E. ANTIETOM ST.

32. Registrar's Signature

HAGENSTOWN, MED

		1 - For State Registrer  1. Decedent's Name (Firs.	t Middle Last		-		t of Health and e of Death	2. Date of D	Reg. No.	U U 4	42004
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permit. Pages 1 and 5 Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 X Burial 2 ☐ Crer	nation 3 🗆 R	BITICVALITOTI STATE	b. Place of Dispo cemetery, cre		1	c. 18, 2004	20c. Lo	cation - City o	or Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav December 15, 2004 4c. County of Death AGATHA HII

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring HOLY CROSS HOSPITAL MUNTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1□M 2□F 577-30**-**4166 May 12,1924 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1√2 Yes 2 □ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1410 3rd Street SW Apt.#20 20024 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Retail Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ambrose Brown Florence Fannie Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1410 3rd Street SW Apt.#20 Washington,DC 20024 Melvin Hill / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veteran Cem. 12/20/04 Cheltenham, Maryland 21. Signature of Funeral Service Licensee Alexander S. Pope 5538 Marlboro Pike Funeral Homes e Forestville, M Md. 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0061768 12-15-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fabienne Santel, MD 1500 Forest Glen Rd. Silver Spring, Md. 20910 2. Registrar's Signature

St

or Attending Physician:

Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year) DEC 2 1 2004

2. Registrar's Signature

When It Sports

DHMH 17 Rev 1/2001

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than 1ry or other traumatic svent, the Ma

**Physician** 

Examiner

/Medical

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Certification:

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**Funeral Director** 

Completed by

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, \$10d PERFH C839 Certificate of Death Reg. No. 2. Date of Death Day **Physician** 11, 2004 10:50 P M Dec. Ann Marie Thornett Miller Haack /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville, MD Montgomery | If Under 1 Year | If Under 24 Hrs. | S. Date of Birth (Month, Day, Year) | Dec. 22, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 210 F 74 73 Yrs. Washington, D.C Director 578.40.3588 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Modest Examinating that be notified at TYPES 2 No Director Germantown MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15014 Spring Meadows Drive 20874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: TENever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Be Completed by Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, Ire Mente 2008. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Catherine Fleishell Geoffrey Matthew Thornett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Allison N. Miller, III / Son 1120 Pipestem Place, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gabriels CemeteryDec.15.2004 Potomac, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. low 5130 Wisconsin Ave. N.W., WDC Fig. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** d eumonia resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deeth? Completed by 3 Probably abstruct 1 ☐ Yes 2 ☐ No 4 Unknown Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dzikinsonism 24a. Was an page 2 autopsy performed 1 Yes 2 No or Attending Physiclan: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year)
DEC 2 3 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Russell

29c. License number

29d. Date signed (Month, Day, Year)

	1.	Decedent's Name (First, Middle, La	LM st) Per PHYS	<del>L &amp; / &amp; &amp; / \</del>	74		2. Date of Death	g. No. Day Year	3. Time of Death
ysician Medical		Theresa Hi	11				December		12:30a <sup>M</sup>
aminer		Facility Name (If not institution, giv				or Location of Dea	th	4c. County of Dea	
1		5402 Brooke Jane Social Security Number 6.5		rs. last birthday)	Clinton		8 Date of Birth	Prince Ge	
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3	10	a. State 10b. County		City, Town or Lo					10d. Inside City Limits
Director		D.C.	W	ashingto	on, D.C.				1 Yes 2 □ No
Dire	10	e. Street and Number			10f. Zip Code			g. Citizen of What Co	
Funeral	-	.802 Bay Street,	12. Was Decedent Ever in	1 U.S. 13.	20003 Was Decedent of	3 Hispanic Origin? (5 ban, Mexican, Puer		nited Stat	
þ		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ♣ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		lf Yes, specify Cui 1 □ Yes 2 ☑ No		to Rican, etc.)	Black, Whit	Black
Completed		15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of wo ed)	rking	6b. Kind of Business	/Industry
Com		10	College (1-401 3+)	Domes	stic Worl	ker		Private	
To Be (	17	. Father's Name <i>(First, Middle, Last,</i> Jnknown	)				me <i>(First, Middle, M.</i> e Tyler	aiden Surname)	
	15	Pa. Informant's Name/Relationship (	Турө, Print)	19b. Mailir	ng Address (Stree	at and Number or R	ural Route Number,	City or Town, State, 2	Zip Code)
and		Billie V. Hill/Da		6402	Brooke 3	Jane Dr.,	Clinton,	MD 20735	
50	20	a. Method of Disposition  12 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		natory or other pla			Oc. Location - City or	
injury or other treumatic event, the Nedical Exercit extransi be rediffied at g.  To Be Completed by Funeral Director	2	<ul> <li>4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer)</li> </ul>	99			etery 12/		linton, MI	
any injury or othar treumatic evant, the Magnes.  To Be Compl		·allh	Mille	A 55	exander 30 Marll	S. Pope	Funeral Ho	omes ille. Mu	20747
burial-transit abui	In di	3a. Part1. Enter the disease, or com shock, or heart failure. List only mediate Cause (Final sease or condition sulting in death)  equentially list conditions, any, leading to immediate use. Enter Underlying at initiated events sulting in death) Last	b. Due to (or as a cons	sequence of):	restm	1	o or respiratory arres	21,	Approximate Interval Between Onset and Death Con Know V
by Physician/Medical E		FEMALE: Bb. Was decedent pregnant in the past 12 months? 1  Yes 2  6	_d	etal death 3	Ectopic pregnand Other (specify)	су		23d. Date of del Month	ivery Day Year
by	Pa	rt II. Other significant conditions of	contributing to death but not	resulting in the u	nderlying cause g	iven in Part I.		icco use contribute to	the cause of death?
Completed	-	Harper 2	oster				24a. Was an autopsy performe	24b. Were au prior to death?	topsy findings available completion of cause of
director, page	25	. Was case referred to medical examiner?					ath (Check only one)		
	27	1 Yes 2 100  Manner of Death 1 Defined 5 Pending investigation			28c. Inju		dome Statesiden 28d. Describe how		Rester
neu		3 Suicide 6 Could not b 4 Homicide determined		t home, farm, str ecify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
neu			vsician: To the best of my l	nowledge, death	occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the cau arred at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
filled in by the funer	29	Da. Certifier 1 Certifying Ph (Check only 2 Medical Exar	niner: On the basis of exam and manner stated.	macton amore in					
dompletely filled in by the funer.  Medical Certification;		(Check only 2 Medical Exar	niner: On the basis of exam	mation and/or m		se number		d. Date signed (Monti	
rilled in by the funer		(Check only 2 Medical Exar	niner: On the basis of exam	manor and/or m					n, Day, Year)  2, 10, 04  20 YAZDAN,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Robert. Henry 12:28 P<sup>M</sup> Dec 14 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hopsital Center Clinton Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Oct 6 1965 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1<del>⊊</del>M 2□F 39 212 90 3097 Director Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural, or iteme 23s or 28s-f show event, the Medical Exemples must be notified at Maryland Charles Waldorf 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 United States 2644 Schult Place 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene. ent: If item 27 ie marked other than "natural", or ite 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food sales Retail Delivery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martha F. Allen John Edgar Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B15 Hawknest Ct. Mathews NC 28105 John Edgar Henry- father 20b. Place of Disposition (Name of cemetery, crematory or other place) 19
Philadelphia Baptist Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 2004 permit. Pages Department of Importent: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Marshville N.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism Physician /Medical Due to (or as a consequence of): **Examiner** Hypercoaqulable State Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certiticate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Tes 2 No Hospital: 1 Inpatient 2X R/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 0005 3219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zafar Ansari, M.D. 7 Post Office Road Cenna Center Suite E Waldorf MD 20602 10 31. Date filed (Month, Day, Year) 32. Registres Signature State DEC 1 7 2004 > Registrar

			1 - For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artment of rtificate of	Health and Death	Mental Hygie	ene2001	42010
	Physici	an	Decedent's Name (First, Midd     Lillian Hardi						2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution		umber)		4b. City, Town,	or Location of Dea	December	4c. County of Dea	4   1:00
	Lxaiiii	101	Brooke Grove	Nursing	Home		Sandy	Spring		Montgome	erv
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🔀 F	7. Age (/	n yrs. last birthday	<del></del>	If Under 24 Hr			rthplace (Stete or Foreign ountry)
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	ow I		10a. State 10b. County	1	10	Oc. City, Town or L	ocation			·	10d. Inside City Limits
	Many a-f-ah	tor	Maryland Mon	tgomery		Silver S	pring				1 ☐ Yes 2 ☑ No
	or 28,	Directo	10e. Street and Number				10f. Zip Code		100	. Citizen of What C	ountry?
	ath wi		2104 Hermita	je Avenue			2090			USA	
	er dez	Funeral	11. Marital Status	12. Was De	Forces?	er in U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
5	hours after death with the Maryland lural', or items 23a or 28a-f ahow al Examinar must be notilited at	by F	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorce	If Yes (	2 ☑ No Sive Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh	ite
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7	be filed withintal Hygiene. d other then		9	(		Hon	nemaker	1		Own Home	
yland	ntal Hed of	Be	17. Father's Name (First, Middle,  James H. Hall						ame (First, Middle, Ma	iden Sumame)	
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Z	od 2 strau		Bettie F. Del		~h + ~ =				, Silver S		
банттоге,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other fraumatic as once.		20a. Method of Disposition		,	20b. Place of Disp	osition (Name of matory or other pla			c. Location - City or	
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	apartr aports ny inje		21. Signature of Funeral Service	Licensee	2			ess of Farinyin	s Funeral		
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5	ğ % .	-	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendii 2 Accident investi	28a. Dat	Inpatient e of Injury onth, Day Ye	28b. Time o	of 28c. Inju	rv at	Home 5 Residence 28d. Describe how	e 6 □Other (Spe injury occurred	cufy)
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	he Hospit in 24 hour he Funera pletely fille	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medicel	Examiner: On the	he best of m basis of ex inner stated	amination and/or in	h occurred at the to vestigation, in my	me, date and plac opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
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	5			MAHAI	K. N	M		3700	D	ecember	15, 2004
			30. Name and address of person					1.14 . 4		N	
	Sta	to.	31. Date filed (Month, Day, Year	32.	Registrar's	Signature &	- 2	JILLI AM	SPORT. M	<u> </u>	
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State of Maryland / Department of Health and Mental Hygiene

					•	Certificate of		R	eg. No2 0	04	42011
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	/Medic		Dorothy A. Hard					Decembe			4:35 p.m.
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	Funeral Director			1 M 2 F	(In yrs. last birth	nday) If Under 1 Year Months Days		8. Date of Birth (Month, Day March 1:	, Year) <b>3,</b> 1913	9. Birthpl Coun <b>Mar</b>	ace (State or Foreign try) yland
	end w		10a. State 10b. County	1	10c. City, Town	or Location				10	Od. Inside City Limits
	Mary 1 sh	5	Maryland Howard		Mt. Ai	ry					1 ☐ Yes 2€ No
	vith the Marylen or 28a-f show be notified at	5	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Coun	try?
	3a or		17197 Hardy Road			21771	L		U.S.A		•
	death	Jera	11. Marital Status	12. Was Decedent E	ver in U,S.	13. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No-		e - America	
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п	be filed wit stal Hygiene d other the event, the	Be	17. Father's Name (First, Middle, Last	)	B		18. Mother's Nam			ne)	
yla	should be find Mental Remarked of	၉	Henry Smith Ni	kirk			Laura	Spurrie	r		
lar	2 sho		19a. Informant's Name/Relationship			Mailing Address (Stree			_		
	yes 1 and 2 of Health of item 27 i		Marjorie Wetzel	- daughter		545 Hickory	Lane, N				21771
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from State	cemetery	Disposition (Name of crematory or other pla ove Cemete:			20c. Location -	•	wn, State Maryland
alti	mit. Dartm Sortal	-	21. Signature of Funeral Service Lice		7	22. Name and Addre	4 F104	auffer			
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	Physician		Immediate Cause (Final		C 0 = 1.					/	144 45
-	Examiner		disease or condition resulting in death)		EPS15					H	LOURS -2 DAGS
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Sic	Attending or death. ector: After by the fune	cat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	Δ			Yes 2 □ No	001 1			Don't March
Ξ	or At efter of Direct	Certification:	4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farn <i>(Specify)</i>	n, street, factory, office		28f. Location (St. City or Town	reet and Numb n, State)	er or Hurai	Houte Number,
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	To the Hospital or Attending Physician: within 24 hours efter death.  To the Funeral Director: Atter this certifica completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of niner: On the basis of e and manner state	xamination and/	death occurred at the tile or investigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, da	ause(s) and ma ate and place, a	inner as sta and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of confider	///		29c. Licens		25	9d. Date signed	d (Month, E	Day, Year)
			1/blle			102	499	T	Decembe	r 20.	2004
	(p		30. Name and address of person who	completed cause of dea	ath (Item 23a) (T	ype, Print)	V				
	1		Ronald E. Mille	r, M. D	4 Culwe	11 Drive, M	lt. Airy,	Maryland	1 2177	1	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	( Annalle)					
	Registra	ar	DEC 2	) ZUU4 DE	BURE SI	1 all and a second					

			1 - For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment of H	lealth and Death	F	Reg. No.	004	42012
	Physicia		1. Decedent's Name (First, Middle, La Roy Michael					2. Date of Dea Month Decemb		2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of De	ath	4c. Cou	nty of Death	,
			Frederick Memo			Freder				rederi	
	Funeral Director		290-48-8128	To Age (In yrs	3 Yrs.	Months Days	If Under 24 H Hours Mi		v. Year)	9. Birthp Cour Ohic	place (State or Foreign htry)
1	land		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Le	ocation				1	0d. Inside City Limits
	Mary -f sh	to	Maryland Frederic	rk	Fred	erick					1⊠Yes 2□No
:	or 28c	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
:	23a (	aic	1505 W. Patrick	Street		217				ed Sta	
-	tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	- 14. F	Race - Americ Black, White,	
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If time X7 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Evant artifust to inclibed at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 12 Yes 2 □ No If Yes, Give Year or Dates: Vie		1 ☐ Yes 2 🖾 No	Specify:			iony.	nite
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ע	1 and Heali Iem 2 other		Matthew R. Horton 20a. Method of Disposition		Place of Dispe	osition (Name of		Date Date		on - City or To	
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	)	- 11	30. Name and address of person who	completed cause of death (It	em 23a) (Type,		, 101		6-1	(0)	/
	_		Dennis Winters				ive Fr	ederick,	Maryla	nd 217	02
F	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev Year HINES DIANA L. Dec 15 2004 9:55 P.M 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Prince George's BRADROD OAKS NURSING HOME If Under 1 Year 7. Age (fn yrs. fest birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🙀 F Days 89 Yrs. June 27,1915 Candor, N.C. 238-36-0204 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 Ves 2 □ No Oxon Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 812 Quade Street 20746 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 7 No Specify: Specify: **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Dry Cleaner Operator Private Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sandy McCaskill Isabella Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sarah Belo/daughter 812 Quade Street Oxon Hill, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 X Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Oak Hill Cemetery 12/20/04 Candor, N.C. 22. Name and Address of Fecility
Frazier's Funeral Home, Inc. 21. Signature of Funeral Service Licensee Hedgman MO1374 389 R.I. Ave., N.W. Wash. .D.C. 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death AlZIfeimors Immediate Ceuse (Final diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 🗆 (No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

**Funeral** 

Director

tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

and Mental Hygiene.

Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve

Pages 1 and 2 should

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

hes

Physician/Medical

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Completed

Be

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Certification:

edicai

3 ☐ Suicide

4 T Homicide

(Check only

or Attending Physician: The law requires that the deeth certificate be executed To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af filled in by

Division of Vital Records, P.O. Box 68760,

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) - Mion T. State

Registrar

31. Dete filed (Month, Day, Year) DEC 2 0 2004

29b. Signature and title of certifier

investigetion 6 ☐ Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

11701 Livings to Road, Fat WASH, you nory/mo

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

D35 206

28f. Location (Street and Number or Rural Route Number, City or Town, State)

December 17, 2004

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month 2004 5:30 PM December Kendrick Yale Hodgdon 13, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 945 Weires Avenue LaVale Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 01/28/1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country 006-10-0181-A 88 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exercises. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits MDAllegany LaVale 1 ☐ Yes 2 ☐ No Funerai Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 945 Weires Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Principal Public Schools 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willis L. Hodgdon Addie Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn R. Hodgdon /wife 945 Weires Avenue, LaVale, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Hillcrest Mem, Park 12/17/2004 Cumberland, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fyneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, F.A. 404 Decatur Street, Cumberland, MD 21502 allemen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2` Diseminate Metastasis from Prostate Primary years Pnysician /Medical Due to (or as a consequence of): Examiner Adenocarcinoma of Prostate 4 ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ulcerative Proctitis with bleeding 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Pre-diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🖔 No Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral. 27. Manner of Death 1 △Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etailed. 29a. Certifier Medical 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D13601 December 14, 2004 -Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop Walsh Road, Cumberland, MD 21502 V.R. Felipa, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			_ For	State of N	laryland / Dep			lental Hyg	iene	1
			1 - For State Registrar  1. Decedent's Name (First, Midd)	the finesh	Ce	ertificate of	Death	2. Date of Deat	eg. No2 0 0 4	42016
	Physici /Medic		Frances	E.	Harman			Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution	on, give street and number	")	4b. City, Town, o	r Location of Death		4c. County of Death	<del></del>
			SACRED NE.  5. Social Security Number	ART HOSD	ge (In yrs. last birthday	CUMb If Under 1 Year	erland If Under 24 Hrs.	8. Date of Birth	HLLEGA 9 Birth	place State or Foreign
	Funeral Director		234-38-9124	404 205	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sep 20,	1924	XXV
	land w		Usual Residence of Decedent  10a. State 10b. County	у	10c. City, Town or L	ocation				10d. Inside City Limits
	d within 72 hours after death with the Maryland jiele r than "naturel", or Itams 23e or 28e-f show The Medical Examination Indiffed at	ctor	WV Mine	eral	Keys	er				1 □ Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 500 Carskadon	Lana Ant 20	6	10f. Zip Code	26726	10	0g. Citizen of What Cou USA	ntry?
	ms 23	erai	11. Marital Status	12. Was Deceder		. Was Decedent of H		ecify Yes or No-	14. Race - Ameri	
36	or Ita	by Fur	1 Never Married 2 Mar	If Yes Give X	]No	1 Yes 2 No	Specify:	Hican, etc.)	Black, White	
00-	2 hour			nt's Education	16a. Dec	edent's Usual Occup	ation		Specify: whit	
215	within 73 ene. than "n	Completed	Elementary/Secondary (0-12)	est grade completed)  College (1-4o	5+)	e kind of work done DO NOT use retired	during most of worki d)		S 1 1	
d 21	file Hyg Int,		12 17. Father's Name (First, Middle,	, Last)	Home	maker	18. Mother's Name		Own Home Maiden Surname)	
/lan		To Be	John Lechlite	er			Ida Mae	Logsdor	n Lechliter	
Maryland 21215-0036	d 2 sh h and 7 is m traum		19a. Informant's Name/Relations Anna Clay	ship <i>(Type, Print)</i> daug		ing Address (Street A. Street	and Number or Rura	Keyser Kumber,	City or Town, State, Zi	V 26726
Baltimore,	of H of H if itan		20a. Method of Disposition 1 🗷 Burial 2 □ Cremation		20b. Place of Disp cemetery, cre Fort Ashby	osition (Name of ematory or other place Cemetery	ce)		Fort Ashby	own, State
<b>3altin</b>	permit. Pag Department Important: any injury o		'4 □ Donation 5 □ Other (S			22. Name and Addre Scarpell			TOITTION	
	<b>2</b> □		23a. Part1. Enter the disease, o	or complications that cause	ed the death. Do not er				and, MD 21502	Approximate
M	Prrysician /Medical Examiner		shock, or heart failure. Lis Immediate Gause (Final disease or condition resulting in death)	a. Que to (or a	line.  brovercul s a consequence of):	1-	4			Interval Between Onset and Death
M	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	<	s a consequence of):					
8760,	te be executed ysician and e burial-transit		that initiated events resulting in death) Last	cDue to (or a	s a consequence of):					
9	ificate g phys as the	edical		d						
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 's should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of deliv Month	ery Day Year
s, P	res that igned b be deta	by	Part II. Other significant conditi	ions contributing to death	but not resulting in the	underlying cause giv	en in Part I.		eacco use contribute to t	
Vital Records,	w requir been si should	Completed				·	<del></del>	1 ☐ Ye	1	pably 4 Unknown
Re	<u>ө</u> - ө	ошо						autopsy perform	y prior to co	mpletion of cause of 2□No
/ital	Physician: Th this certificate ral director, pag	BeC	25. Was case referred to medica examiner?			21	26. Place of Death	(Check only one	э)	
of	Physic r this c	): To	1 Tes 2 No 27. Manner of Death	Hospital: 1 Inpa 28a. Date of In	jury 28b. Time		4 Indising Ho		nce 6 Other (Special winjury occurred	(y)
ion	Attanding Is death. actor: After by the funer	atior	L _ / tooldorit	ing (Month, E tigation	ay Year) Injury		k? Yes 2 □ No		, ,	
Division	i Sitte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 288. Place of t	njury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location (Str City or Town	reet and Number or Run , State)	al Route Number,
	To the Hospitel or within 24 hours after to the Funeral Director completely filled in	edicai C	29a. Certifier (Check only one)  Certifyi 2 Medical	ing Physician: To the besi Examiner: On the basis and manner:	of examination and/or is	th occurred at the tir nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as s ate and place, and due t	tated. o the cause(s)
)	To the within 2 To tha complet	Me	29b. Signature motitle of certific	Sohn		29c. Licens			ed. Date signed (Month,	
	100		<u></u>	n who completed cause of	death (Item 23a) (Type	, Print)	00:	1-	10 10	10 21502
	Sta	te	31. Date filed (Month, Day, Year	R Smith  32. Again	trar's Signature		DRIVE	CUMD	erind, 11	10 × 1502
	Registr	ar	JAN 0	4 2005	trar's Signature	port				
DH	MH 17 Rev 1/2	001			0.7					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** December 20,2004 2:25 P.M. Lillian Pearl Houck /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Washington Williamsport Nursing Home Williamsport If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) Funeral Days Hours 1□ M 25 F 87 Yrs. February 22,1917 Director 225-74**-1**899 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits tha Maryland 10a Stete 10b. County parmit. Pagas 1 and 2 should be filad within 72 hours attar daath with tha Maryla paperment of Health and Mantal Hygians. It is the state of the should be any fulled at any fuller of other traumatic event, the Maddall Experient must be notified at 1 Yes 2 □ No Directo Takoma Park Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20912 USA 29 Hickory Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Yes 21 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cafateria Employee Federal Government 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Mae Stone Clem Jordan Morgan 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 248 Ridersville Road Berkeley Springs, WV 25411 Donald L. Houck/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/04 Ashe County, NC Bethany U.M.Cemetery 22. Name and Address of Facility 21. Signature of Fineral Savice License 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Cerebrovascular accident 10 days Examiner il Records, P.O. Box 68760, The law requires that the death cartificate be associated by Due to (or as a consequence of): Examine dependent insulin Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, hypertension Completed by Physician/Medical Due to (or es a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Vascular disease post 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? bilateral below knee amoutations 1 Vec 2MNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) centre Kuther Sands, me December 20,2004 D47451 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Narsing Home 154 North Artizan Street -Sands Williamsport Maryland 21795 MD 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State JAN 0 4 2005 Elave & Spark Registrar

**ORIGINAL** 

**DHMH 16 Rev 6/95** 

			State of M		artment of Health and			
			For State Registrar		rtificate of Death		nog. N2004 42018	3
	Physicia	an	Decedent's Name (First, Middle, Last)     SUE ANNE HARRELL			2. Date of Dea Month	Day Year	
	/Medic	al	4a. Facility Name (If not institution, give street and number)	,	4b. City, Town, or Location of Deat	DEC	19 2004 5:05 A <sup>N</sup> 4c. County of Death	
	Examin	er	CIVISTA MEDICAL CENTE		LAPLATA		CHARLES	
	Funeral		5. Social Security Number 6. Sex 1	ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day	9. Birthplace (State or Foreig Country)	ın
	Director		Usual Residence of Decedent	00		MAY Z	1,1938 WASH.,DC	
	death with the Maryland ms 23a or 28a-f show r must be radiiled at	2	10a. State 10b. County	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 1 → Yes	
	the M	Director	MARYLAND CHARLES  10e. Street and Number	BEL ALT	10f. Zip Code		10g. Citizen of What Country?	_
	h with	al Di	9365 BEL ALTON NEWTOWN	ROAD	20611		U.S.A.	
		Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.	
20	filed within 72 hours after death with the Marylan Hygiene. ther than "natural", or Items 23a or 28a-f show ant. Its Macheal Examinat must be indiffed at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ No Specify:		Specify: WHITE	
2-003p	72 hours "natural", dical Exa	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation	rkina	16b. Kind of Business/Industry	
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Z D			1.1 17. Father's Name (First, Middle, Last)	CDE			Maiden Sumame)	
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Mary	s 1 and 2 should t Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Re			
e `e	1 and Health em 27 ther ti		JEAN BENNIS-DAUGHTER  20a. Method of Disposition		QUADE CIRCLE,	WALDOI Date	RF, MD 20646  20c. Location - City or Town, State	_
DE L	e 2 = 5		tXXurial 2 ☐ Cremation 3 ☐ Removal from State		sition (Name of natory or other place)  ERANS CEM. 12-	22 04	,	
Баітітог	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee MOO47		Name and Address of Facility AYMOND FUNERAL		CHELTENHAM, MD	
מ	89 5 8		Muchal Of	L	A PLATA, MARYI	SAND 20	0646	_
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limited Cause (Final	the death. Do not entended	er the mode of dying, such as cardia	c or respiratory arr	rest, Approximate interval Between Onset and Death	
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence of):	electic I teat	t June	<u>e</u>	
	Examiner			ALCONSOLUE OF .	0.0			
( )	sit ad	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):				
	be executed ician and burial-transii	Examiner	that initiated events.	a consequence of):				
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200	certificat nding phy use as th	hysician/Med	IF FEMALE:					
X Q	death c	clan/	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year	
	the	hysi	1 Yes 2 No 9 Unknown					
S,	w requires that been signed b should be deta	by P	Part II. Other significant conditions contributing to death b	out not resulting in the un	nderlying cause given in Part I.		bacco use contribute to the cause of death?  es 2 No 3 Probably 4 Onknown	
ecords		ompieted	College of Statutes	hulker			William -	
Ye.	sician: The law s certilicate has b irector, page 2 sl	ompi	Cardio magnating			24a. Was a autops perfori	prior to completion of cause of death?	,
	ian: T	e C	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes ath (Check only or		_
O T <	≥ .22 ⊅	To B	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatio	-			ence 6 Other (Specify)	
	ate:	ion:	27. Manner of Death  1 Natural 5 Pending (Month, Da	ary 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe he	ow injury occurred	
JIVISION	Attending ir death. ector: After by the fune	ificat	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury	jury - At home, farm, stre			treet and Number or Rural Route Number,	-
5	tal or safter all Dire	Certification;	4 Homicide determined building, et	tc. (Specify)		City or Town	n, State)	
	Hospi Hospi 14 hour Funer Fely till	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of	f examination and/or inv	occurred at the time, date and place vestigation, in my opinion, death occur	e, and due to the curred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)	
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely lilled in by the to	Med	one) and manner st 29b. Signature and title of certifier	ated.	29c. License number	2	9d. Date signed (Month, Day, Year)	
	->-0		> 75m + 12	Land M	D-01009		12-19-04	
	10		30. Name and address of person who completed cause of c					
	(0)		HENRY L. BURKE MD 11 31. Date filed (Month, Day, Year) 32 Aegistr	5-A LA GR	ANGE AVE P.O.	BOX 25	39 LAPLATA MD 2064	<del>'</del> 6
-	Sta Registr		JAN 0 4 2005	. It do	made a			

			For State Registrar	State of M	laryland		artment <i>tificate</i>					giene 0	04	42019
	Physicia	20	1. Decedent's Name (First, Middle,	Last)							2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic		Hazel Thelma	Jackson			4. 65. 3		red Selection	(0 "	Decemb		2004	6:30 a M
	Examin	er	4a. Facility Name (If not institution, 1602 Jarvis Ave		)		0xon		Location o	of Death			nty of Death	<b>*</b>
	Francis				ge (In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of Birt	th	ce Geo	place (State or Foreign
П	Funeral Director		579-18-2424	1□M 2⊠F	94	Yrs.	Months	Days	Hours	Min.	May 29	, 1910	Wash	ington, DC
	۵ , ع		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							10d. Inside City Limits
	Aaryia f sho	้อ	Maryland Prince	George	-	Hill	oution,							¥ Yes 2 No
	with the A is or 28a-	Direct	10e. Street and Number 1602 Jarvis Aven				10f. Zip	Code 2	0745			10g. Citizen o United	of What Cour State	ntry? S
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: If item 27 is marked other then "naturel; or items 23s or 28s-f show any injury or other traumatic event, the Medical Exacilinal count to notified at ange.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1	? ]No	1	Vas Decede f Yes, spec 1 ☐ Yes 2	ify Cubar	n, Mexican	n, Puerto I	cify Yes or No Rican, etc.)		lace - Americ llack, White, city: B1	
Š	2 hou	ted	15. Decedent's			16a. Deced	lent's Usua kind of won	l Occupa	ition	t of working	10	16b. Kind of	Business/In	dustry
21215-0036	ithin 7 9e. 1en "r	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT us	e retired)	)	i or workir	<i>'</i> 9	Dome	atio	
7	tygier tygier ther th		12 17. Father's Name (First, Middle, L	act)		Hou	sewif	e	18 Mothe	ar's Name	(First, Middle,			
anc	d be fi	To Be	Andrew Price	131/							Norri		a,,,o,	
Baltimore, Maryland	nd 2 should the and Me 27 is mark	Ĕ	19a. Informant's Name/Relationshi Helen Jackson/I			19b. Mailin 10864 Si 1ve	ag Address Buck r Spr	(Street a	nd Numbe Driv MD	or or Rura ve . A	Route Numbe	er, City or Tov	vn, State, Zip	Code)
re,	s 1 ar		20a. Method of Disposition		20b. Plac		sition (Nam				ate	20c. Locatio	n - City or To	own, State
E	Page ment ent: If ury or		1 ☐ Burial 2 € Cremation  4 ☐ Donation 5 ☐ Other (Sp.				tan C			12/2	23/04	Alexan	dria,	Virginia
Balt	permit. Departr importe any inj		21. Signature of Funeral Swice L	Mill	$\sim$	A <sup>22</sup> 55	Name and exand 38 Ma	er S .rlbo	s of Facility PO	pe Fu ike/I	neral Forestv	Homes ille,	MD 20	)747
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause nly one cause on each	ed the death. line.	Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
	Priysician	1	Immediate Cause (Final disease or condition resulting in death)	_a. CONI	GRST	11/12	H	20	27	FIN	ILUK	R		Oliset and Death
	/Medical Examiner		resulting at deality	Due to (or a	s a conseque	-	51-1	,						
	25.00	ē	Sequential   list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a conseque		5/01						-	
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	С.										
o,	ate be executed hysician and the burial-transit	Еха	resulting in death) Last		s a conseque	nce of):								
8760,	ate the	dicai		d.						_			-	
Box 6	ulfic g p	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			-					23d.	Date of deliv	ery
P.O. B	that the death cer ed by the attendin detached tor use	Physician/Medicai	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown			Ectopic pre Other (spe						Month	Day Year
-	requires that the een signed by th nould be detache		Part II. Other significant condition	s contributing to death	but not resulti	ing in the u	nderlying ca	ause give	n in Part I		23e. Did t	obacco use co	ontribute to t	he cause of death?
rds	w requires that s been signed t should be deta	d by	CHRONIC C	BSTRUC	TIVE	PU	CMO!	VAR	pis	5/245	E 10'	Yes 2⊒No	3 ☐ Prot	oably 4 Unknown
CO	≥ Q 50	Completed				,		/			24a. Was	an 24	b. Were auto	ppsy findings available mpletion of cause of
Re	9 4 9	mo										rmed?	death?	
ital	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)		
× ×		မ	1 Yes 2 No	Hospital: 1 🗆 Inpai		R/Outpatien		-	4 LI NU		ne 5⊉Resi		(-1	'y)
Division of Vital Records,	ling P	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		jury 2 Jay Year) 2	8b. Time of Injury	M 2	Bc. Injury Work	at ⊲? ∕es 2 🔲		28d. Describe I	how injury occ	curred	
isio	Attending or death.	ficat	2 Accident investigation of Could not determine	ot be 28e. Place of I	njury - At hom	e, farm, str			. 65 2				mber or Run	al Route Number,
Ω	after i Dire	Certification;	4 Homicide	building,	etc. (Specify)	.,,	,	,			City or To	wn, State)		
	To the Hospitel or Attending Physical thing 24 hours after death. To the Funeral Director: After this completely tilled in by the funeral director.	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manners	of examinatio	edge, death n and/or in	n occurred a vestigation,	at the tim	e, date an pinion, dea	nd place, a oth occurre	and due to the ed at the time,	cause(s) and date and plac	manner as see, and due to	tated. o the cause(s)
	To the l within 2 To the I	Me	29b. Signature and title of certifier	10.	PH	YSICIA	29c	License	number			29d. Date sig	ned (Month,	Day, Year)
•			W-Kit	· Chit				000	054	54	7	12/	20/01	1
2	(3)		30. Name and address of person w	EN 739	OVA.	ND	Print) USEA	1 R	0 5	SUIT	= 350	CAU	erc	MARCRI
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 2 1 2		strar's Signatur		de							

			For State Registrar	State of	Maryland	•	artment of I		d Mental Hy	giene	04	L2020
	Physici		1. Decedent's Name (First, Middle, L	u Brown	Johnson		ľ		2. Date of De Month	Day Der 12, 2	Year 2004	3. Time of Death 8:30A M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and num	iber)		4b. City, Town, C	r Location of De L Height	eath	4c. County		
ſ	Funeral Director		5. Social Security Number 6. 578-54-5283	Sex 1□M 2基F	7. Age (In yrs. Id 62		If Under 1 Year Months Days		in (Month Da	av. Year)	Coun	ace (State or Foreign try) Lngton, DC.
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George		Town or Lo	cation Heights				10	0d. Inside City Limits 12☑Yes 2☐No
	3a or 28a	al Director	10e. Street and Number 6418 Seat Pleas	ant Driv	e		10f. Zip Code 2074	÷3		10g. Citizen of V		•
36	be filed within 72 hours after death with the Maryland that Hygiene. So other then "natural", or items 23a or 28a-f show event, the Mexical Eventral method to the filed at a yeart.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Dece Armed For 1  Yes If Yes, Give Year or Da	2 <b>⊠</b> No 9		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Blac	e - Americ k, White, Bla	etc.
Maryland 21215-0036	within 72 hou ene. then "nature the Medical E	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th			(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of d)		16b. Kind of Bu		,
land 2	should be filed within nd Mental Hygiene. marked other then umatic event, the Mental country of the Menty of	To Be Co	17. Father's Name (First, Middle, Las Wesley Brown	ot)		Admirit	ISCIALIVE	1	Name (First, Middle			riment
	es 1 and 2 should bot Health and Ment itam 27 is marked rother treumatic a		19a. Informant's Name/Relationship Kenneth O. Polla		on				Rural Route Numb			
altimore,	Page nent ent: fi		20a. Method of Disposition 1   Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Special Control of the Control o		State	emetery, crei	esition (Name of matory or other pla Memorial	.	Date . 17,2004		d, MI	
Balt	permit Departr Importe any inji		21. Signature of Fogeral Service Lic	)///	Life		2. Name and Addre		Forestvi	neral Hor rlboro P lle, MD.	mes ike 20	747
	Physician /Medical Examiner	ner	shock, or heart failure. Est on Immediate Cause (Final disease or condition resulting in death)  Sequential/ list conditions. If any, leading to immediate cause. Enter Underlying	a. <u>Meta</u> Due to (	ach line.	Ovaria Jence of): Obstru	ın Cancer		diac or respiratory a	mest,		Approximate Interval Between Onset and Death
,09289	icate be executed physician and s the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last	V	rtensio orasa consequ tes						Ī	
.O. Box 6	The law requires that the death certific tie has been signed by the attending r page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nth 2∏Fetal ant at time of de	death 3[	Ectopic pregnanc Other (specify)	у		23d. Dat Mor	e of delive	ry Day Year
٥	quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to de	ath but not resu	ulting in the u	nderlying cause gr	ven in Part I.		tobacco use contr Yes 2 □ No	ibute to th	
Vital Records,		Completed							24a. Was auto perfi 1 \( \text{Yes}	psy ormed?	Vere autoporior to cor leath?	osy findings available inpletion of cause of
	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA Ot	200	Death (Check only		ar /Snacih	·1
ion of	ling I. After une		27. Manner of Death  1 Avatural 5 Pending 2 Accident investigat	28a. Date of		28b. Time o Injury	f 28c. Inju	CA 194		how injury occurr	, , ,	,
Division		Certification:	3 ☐ Suicide 6 ☐ Could not determine	208. Flace	of Injury - At ho ng, etc. <i>(Specif</i> y	ime, farm, sti	reet, factory, office		28f. Location ( City or To	(Street and Numbe wn, State)	er or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in h	edical	(Check only 2 Medical Exone)		sis of examinat		vestigation, in my	opinion, death o	ace, and due to the courred at the time,	, date and place, a	and due to	the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Is at			29c. Licen	se number		December		
2	(10)		30. Name and address of person wh				Print)			D. 2077	4	
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 1 200	4 Sec. R	egistrar's Signa	Span	W					

State of Maryland / Department of Health and Mental Hygiene 42021 1 - Stata Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2004 DEC. **Physician** IRVING JAMES 16, 4:52 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death **Examiner** SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Y 10-13-32 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 577-42-2617 Yrs 72 PHILA. PA Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner a ust be notified at 1X Yes 2 □ No Funeral Director MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other traumest- any injury or other traumest-14801 PENNFIELD CIRCLE #305 20906 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Mayes 2 □ No 6−14−67 If Yes, Give Year or Dates: 4−30−73 14. Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: BLACK Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE TRUCK DRIVER EXXON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKOWN FLOSSIE BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RIRETTE L. WILKERSON-DAUGHTER 11309 CUSHWA DRIVE CLINTON, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State CHELTENHAM VET. CEM. 12-27-04 CHELTENHAM, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityPINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Funeral Service Licensee 524 - 8TH ST., N. E. heo WASH., DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician AMYOTROPHIC LATERAL SCLEROSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown þ requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perfo Mea? 1 ☐ Yes 25. Was case referred to medical examiner? Physician: funeral director, Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attanding 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAO, TRUONG M.D. 13219 EXCUTIVE PARK TERR. GERMANTOWN, MD 20874 31. Date filed (Month, Day, Year) 82. Registrar's Signature State DEC 2 1 2004 Registrar

			. 101	artment of Health and Ment	al Hygiene 004 42022
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) LUCY H. JOHN SOW	DE	te of Death Day Yeer 3. Time of Death Onth 10:05 PM
	Examin Funeral	er	4e. Fecility Name (If not institution, give street and number)  HOLY CROSS HOSPITAL  5. Social Security Number  6. Sex 1 M 2 X F  7. Age (In yrs. last birthday)	Months Days Hours Min M	4c. County of Deeth  MONTGOMERY  Ite of Birth onth, Day, Year)  9. Birthplace (State or Foreign Country)
	Director Moy		224-34-2985	4	9-28 VIRGINIA  10d. Inside City Limits
	with the Mar la or 28e-f sl	Funeral Director	MD PRINCE GEORGE SUITLAND  10e. Street and Number  4117 CRAB APPLE COURT	101. Zip Code 20746	1 K Yes 2 □ No  10g. Citizen of What Country?  U. S. A.
980	J within 72 hours after death with the Maryland jiene, tran "naturs!", or Iteme 23e or 28e-f show transcript Examiner must be natified at	þ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1   Never Married   2   Married   1   1   1   2   2   2   2   3   1   1   3   3   3   3   3   3   3	Was Decedent of Hispanic Origin? (Specify Y f Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	
Maryland 21215-0036	yithin rithen r then	Completed	(Specify only highest grade completed) (Give life. L	tent's Usual Occupetion kind of work done during most of working DO NOT use retired) ACHER	16b. Kind of Business/Industry  BALTIMORE PUBLIC SCHOO
ıryland	should be filed nd Mental Hygi marked other imatic event, II	To Be	17. Father's Name (First, Middle, Last)  THOMAS HALSEY  19a. Informant's Name/Relationship (Type, Print)  19b. Mailin	18. Mother's Neme (First  BARNETT  ng Address (Street and Number or Rural Rout	
nore, Ma	ges 1 and 2 should nt of Health and Mer : If Item 27 is marke or other treumatic		20a. Method of Disposition  20b. Place of Disposition  20c. Place of Disposition cemetery, cren  20c. TINCOLINE		20c. Location - City or Town, State SUITLAND, MD
Baltim	reimit. Pages 1 an epertment of Heal Importent: If Item 2 any injury or other 2000a.		21. Signature of Funeral Service Licensee	4	NEY-SPANGLER FUNERAL HOME
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the deet. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ERENAL I	Approximate Interval Batween Onset and Death
8760,	sate be executed by sicien and the burial-transit	dical Examiner	b. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):		
O. Box 6	death certific e ettending p id for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ords, P.O.	law requires that the as been signed by th 2 should be deteche	þ	Part II. Other significant conditions contributing to death but not resulting in the ur	ndertying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ Ño 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	The ete h page	e Completed	25. Was case referred to medical		4a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Division of Vil	ending Physath. sath. or: After this he funeral di	Certification: To Bo	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation	28c. Injury at Work?  M 1 Yes 2 No	☐ Residence 6 ☐ Other (Specify) escribe how injury occurred
Divi	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the		4 Homicide determined 299. Place of injury Arrome, farm, stribuilding, etc. (Specify)  299. Certifier 1—Certifying Physician: To the best of my knowledge, death	Ci	
	To the Ho within 24   To the Fu completel	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or invariant and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, 26.09 SECOND A VENUE S)	Print) VERSPRING 1	no 20/10 CICLLAMILIMO
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 2004  32 Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene 2004 - State Registral 42023 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month
DECEMBER 21, 2004 **Physician** WILLIAM THOMAS JACKSON 12:24AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) .Sex XXM 2□F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 58 Yrs. 230 64 2029 Director AUG 05, 1946 VIRGINIA Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at XX Yes 2 No UPPER MARLBORO MARYLAND PRINCE GEORGES Direct 10g. Citizen of What Country? 10e. Street and Number 12010 GREEN TEE TURN 20772 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH FURNITURE MOVER PRIVATE Pages 1 and 2 should be filed vitnent of Heelth and Mental Hygle tant; If itam 27 is marked other taury or other traumatic svent, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANDREW WASHINGTON CELIA HOBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UPPER MARLBORO, MD 20772 JOAN A. JACKSON/ WIFE 12010 GREEN TEE TRUN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State permit. Page Department of Important; If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL PARK 12/28/2004 LANDOVER, MD 21. Signature of Funeral Service Licensee MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Circhosis the Liver Physician /Medical Due to (or as a consequence of) **Examiner** Insufficiency. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed Diabetes physician and is the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s autopsy performe 1 Yes 1 Yes 2X No Division of Vital To the Hospital or Attending Physician: within 24 hours after death. √To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After this 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 X Natural s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12004 Ph D5793 1) m.D. Kav 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CLINTUN SURRATT ZIRONG SHAC 31. Date filed (Month, Day, Year)
DEC 2 2 2004 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DECEMBER 12  $A^{\mathsf{M}}$ MARGARET POLLY 2004 9:30 **JOHNSON** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2√2 F 56 Yrs. Director 239-72-1746 Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumetic event, the Newton Emmiran raust be notified at 1 Yes 2 No Director MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 7524 Surratt Road U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death \text{Oepartment of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items 23s any injury or other traumetic event, the Wudden Examinar must any injury or other traumetic event, the Mudden Examinar must appries. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No ģ Specify: Black 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private 2 yrs Computer Programer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thelma Waite Felix Polly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6200 Terrance Rd. Clinton, Maryland 20735 Mary P. Douglas/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) <del>Li</del>ncoln Cemetery 12/18/04 Suitland, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 20 No if or Attending Physicien: after death. 25. Was case referred to me ✓ I examiner?
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[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kene 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 1 7 2004 Registrar

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212	i withi jiene. r than	ошр	Elementary/Secondary (0-12)	College (1-4or 5	14-1	cher	,		E1	ementary	School
밀	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show raumatic avant, the Medical Evant arthrest by notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother	r's Name <i>(Fir</i> s	st, Middle, Maid	len Sumame)	
yla	Ment Ment Markec	2	Rudolf Adelbert F					-		bella He	
Mar	d 2 sh th and 7 Is rr traum		19a. Informant's Name/Relationship (7) Margot Brooks, Dau			ailing Address <i>(Str</i> e					
<u>ق</u>	Healt Healt tem 2	1	20a. Method of Disposition	girter		sposition (Name of rematory or other p		Date		Location - City or	
OE I	Pages ent of		1 ☐ Burial 2 ☐ Cremation 3 ☐ I  1 ☐ Donation 5 ☐ Other (Specify)		į.		1	12/15/2	2004 Br	entwood.	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Evantment must be notified at once.		21. Signatore of Fun a Service dicens	See	.)	22. Name and Add					nar judin
<u> </u>	8958	10 1	Jouly &	an Us						le, Mary	land 20852
О			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each lin	the death. Do not ne.	enter the mode of d	tying, such as	cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	N I	Immediate Cause (Final disease or condition resulting in death)	a Cardiac							
ı	Examiner		ſ	,	a consequence of): clerotic	Hoort Die	20200				
		Jer	Sequentially list conditions, if any, leading to immediate		a consequence of):	neart bis	sease				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Colon C							
8760,	ate be executed only sician and the burial-transit		resulting in death) Last	· ·	a consequence of):						
387	physical phy	Physician/Medical	•	d. Carcino	id Syndro	me					
Box 6	death certific e attending p id for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		0.05.				23d. Date of de	livery
		sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 □ Pregnant at		3 ∐Ectopic pregnai 5				Month	Day Year
P.0	that the de ed by the a detached	Phys	9 □ Unknown 1				-in-ris Dard I	,	220 Did tohooo	a una contributa t	o the cause of death?
	es gn be	by	Part II. Other significant conditions co Hypertension	ntributing to death b	ut not resulting in the	underlying cause	given in Part i.		1 ☐ Yes		robably 4 Unknown
Records,	w requir been si should	Completed							24a. Was an		utopsy findings available
Re	0 - 0	duic	Arthritis						autopsy performed	prior to death?	completion of cause of
Vital		d)	25. Was case referred to medical				26. Place	of Death (Che	I □ Yes 2 💢 I eck only one)	No 1 □ Yes	2 2 140
of V	S S =	To B	examiner? 1 □ Yes 2X No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpa	ient 3□ DOA	Other: 4 💢 Nui	rsing Home	5 Residence	6 ☐Other (Spe	icity)
o uc	ding Phy th. After this	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Yea <i>r)</i> Injur	y V			Describe how in	njury occurred	
Division	Attanding r death. sctor: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ini	ury - At home, farm,		Yes 2 1		ocation (Street	and Number or R	ural Route Number.
<u>&gt;</u>	after after Dira	erti	4 Homicide determined	building, et		and the state of t			City or Town, St		
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical C		vsician: To the best iner: On the basis of							
	th is the	Med	29b. Signature and little of eartifier	and manner sta	ated.	29c. Lice	ense number		29d. I	Date signed (Mont	h, Day, Year)
)			MA	ucory			3691			cember 13	
	12		30. Name and address of person who o	ompleted cause of d	leath (Item 23a) (Typ				250		
			Ajay Reddy, MD 63		acy Boule	vard, Bet	hesda,	Maryla	and 2081	4	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 15 20		ar's Signature	Spars	2				
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			1 - For Stete Registrar	State o	f Marylan		artment of I rtificate of		and Me		giene 2 (	04	421	027
	Physici	an	1. Decedent's Name (First, Mide							2. Date of Dea Month	-	_Year	3. Time of I	
	/Medic		Gladys Vivian	<del>_</del>						ecembe			6:20	Рм
1	Examir	er	4a. Facility Name (If not instituti				4b. City, Town,				4c. County		•	
			Wilson Health 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Gaither	_		8 Date of Birt		gome1		Foreign
	Funeral Director		579-44-7441 Usual Residence of Decedent	1□ M 2\ F	97		Months Days		Min.	8. Date of Birt (Month, Da) June 2	1907	Sout	place (State or htry) h Dako	ta
	yland		10a. State 10b. Count	ty	10c. Cit	ty, Town or Lo	cation					1	0d. Inside City	y Limits
	a-f sl	ctor	Md. Mont	gomery	Ga	ithersl	ourg						1 ₹ Yes	2 🗌 No
	ih th	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	itry?	
	ath w	rai	301 Russell Av				2087				United			
	er de	Funerai	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Orig an, Mexican	gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)	14. Rad	ce - Americ ck, White,		
36	Ir, or	by	1X Never Married 2 Ma 3 Widowed 4 Divorce	If Yes Gi	ve		1 ☐ Yes 2 🔀 No	Specify:			Specif	v: Whi	ite	
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show disal Examilian reliber caffilied at	ted	15. Decede	ent's Education		16a. Dece	dent's Usual Occu	pation			16b. Kind of B	usiness/Inc	dustry	
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	filed with Hygiene. rther ther	Completed		5-		Nurs	ing Insti				Health		<u> </u>	
nd	m - 0 %	Be	17. Father's Name (First, Middle								Maiden Suman	ne)		
<u>~</u>	d Mental	2	C.R. Robinson			10h Maili	an Addansa /Ctan		Surr		O't T	Ct-t- 7in	0-41	
Maryland	d 2 sl th an 7 is r treur		19a. Informant's Name/Relation Harriet E. Lar		(brai		ng Address <i>(Stree</i> Mount E <sub>1</sub>							
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. F	_	sition (Name of natory or other pla		Da		20c. Location -			
JOE	ages and of		1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other	1 3 □Removal from (Specify)	Jiaio		natory or other pia Ltan Cref	١.	Dec. 2004		Alexand	ria.	Va.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic en once.		21 Signature of Funeral Gervice		00		2. Name and Addr				eral Ho		,	
ä	Depared Important in suny in s		Mich	- WIN	Wille	10	D East De	eer Pa					1. 2087	7
	Physician /Medical Examiner	e	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to	each line.	set quence of):	er the mode of dy	4		respiratory ar	rest,	A	Approximate Interval Betw Opset and D	ееп
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	(or as a conseq									
О. Вох	at the death c by the attend tached for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live I	oirth 2 🗍 Feta nant at time of c	ıl death 3 [	Ectopic pregnanc Other (specify) _	y				te of delive Inth	*	ear ear
ecords, P.	quires that en signed b uld be deta	Completed by Ph	Part II. Other significant condi	cerebr	culas	eul	ascel	cicle			obacco use cont es 2 PNo		ne cause of de ably 4 ⊟Ur	
ပ္သ	aw requise been 2 shoul	plet	with co	rtical	bles	<i>idea</i>	ency Ch	in	a	24a. Was		Were auto	psy findings a npletion of car	vailable
$\alpha$	The tay cate has page 2	E O	anenie	1.						perfor	rmed?	death?	2 No	u3 <del>0</del> 01
Vital	i <b>cien:</b> Th certificate rector, pag	Be (	25. Was case referred to medic examiner?							(Check only o				
*	hys his I di	2	1 ☐ Yes 2 ☑ No			ER/Outpatier					lence 6 Oth		1)	
n o	ling P	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pend		of Injury th, Day Year)	28b. Time of Injury	Wo			Bd. Describe h	low injury occur	red		
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Coul	mined 286. Place	of Injury - At h	ome, farm, str fy)	M 1 =	]Yes 2 □ f	150	Bf. Location (S City or Tow	Street and Numb vn, State)	er or Rura	l Route Numb	Θ <i>Γ</i> ,
	he Hospit in 24 hours he Funere pletely fille	Medical C	29a. Certifier 1 Certify (Check only one) 1 Medica	ring Physicien: To the el Examiner: On the b and man	e best of my kno asis of examina ner stated.	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and opinion, deat	d place, ar th occurred	nd due to the d d at the time, d	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)	
	To t To t	Σ	29b. Signature and title of certif				29c. Licen				29d. Date signe			
•	1		14. Rehe	ctoire	where	face	D041	.15			ecm)	ber	12,0	2004
	>		30. Name and address of personal Dr. H. Robert	Birschback			Print) L Russell	Ave.	Gait					
- -	Sta Registi		31. Date filed (Month, Day, Yea  DEC 1		egistrar's Signa	ature #	Spark	2						

			For Stete Registrar	State of	Maryland		artment rtificate				lental Hy		7 11 11.	42028	}
			Decedent's Name (First, Middle, L.)	ast)					Julin		2. Date of D	Reg. N eath		3. Time of Death	
	Physici		George Lea	~ Kel	bauch						Month		ay Year		A
	/Medic Examir		4a. Facility Name (If not institution, g	ive street and numi	ber)	<u> </u>	4b. City, T	own, or	Location of	of Death	Decemb		c. County of Dea	1 0 0	-
1	LAGIIII	101					Hage								
	Funeral		Washington Count 5. Social Security Number 6.	y Hospit	Age (In yrs. la	st birthday)	If Under 1		If Under		8. Date of Bi	rth	9 Ri	on County	
н	Director		216-30-3445	1 <b>∑</b> M 2□F	70	Yrs.	Months	Days	Hours	Min.	April 8	ay, Year	934 Ma	ithplace (State or Foreig Country) ryland	
	D D		Usual Residence of Decedent										JJ1   III.	Lyland	
	nylan how		10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside City Limits	5
	e Ma	cto	Maryland Washing	ton Co.	Hage	erstov	<b>v</b> n							1 □Yes 2 ➡No	0
	th th or 28	lre	10e. Street and Number				10f. Zip (	Code				10g. C	itizen of What C	Country?	
	72 hours after death with the Maryland neturel', or Items 23e or 28e-1 ehow dical Exambra must be trofffied at	Funeral Director	10419 Crystal Fa	lls Drive	9		217	42				U.	S.A.		
	ems ems	Inel	11. Marital Status	12. Was Deced Armed Forc	ent Ever in U.S es?	13.	Was Decede	ent of His	panic Orig	gin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh		
98	or It		1 ☐ Never Married 2X Married	1 ☐ Yes 2	. No		1 Yes 2		Specify:	, , , ,	riioari, oto.)			ite, etc.	
Ö	urel',	d by	3 Widowed 4 Divorced	Year or Date	es:								Specify: Wh:	ite	
5	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "neturel", or Items 23e or 28e-f ehow event, the Medical Examiner must be rediffed at	Completed	15. Decedent's E (Specify only highest g	iducation rade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done do	tion <i>Iring m</i> ost	t of worki	ing	16b. I	Kind of Business	s/Industry	
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22	filled Hygie ther		10 17. Father's Name (First, Middle, Las	**		Servi	ce Mai			ele Nie er	(F) A (F)		to Deale	ersnip	
Maryland 21215-0036		Be		,				İ			(First, Middle	, Maide	n Sumame)		
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Ma	12 sho h and 7 Is mu treum		19a. Informant's Name/Relationship									er, City	or Town, State,	Zip Code)	
e,	s 1 and 2 should f Health and Mer item 27 Is marke other treumetic		Patsy Ann Kelbaud	jh / Wife		10419	Cryst	tal :	Falls		ive Ha	gers	stown, N	Maryland 21 Town, State	74
Ď			Burial 2 ☐ Cremation 3				sition (Name natory or oth								
ij	t. Partmer		`4 □Donation 5 □ Other (Spec	•	Ceda	ır Law	n Mem.	. Pa:	rk De	C. 2	28,2004	Ha	agerstow	m, Maryland	
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Lice	nsee 7 ·		DO	. Name and uqlas	Δ 1	Fiers	Fir	eral H	Ome			
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ance ot):									
	and I-trar	хап	that initiated events resulting in death) Last	C. Due to (or	as a conseque	nno of):									
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o.		Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow	it at time of dea n	ıth 5∟	Other (spec	cify)					***************************************	<i>-</i>	
۵.	that the di ed by the detached	P.	Part II. Other significant conditions	contributing to deat	h but not result	ing in the ur	derlying cau	ICA CIVAC	in Part I		23e Did t	obacco	uso contributo t	the cause of death?	_
ds,	S G G	0	•			ang in the di	derlying cau	130 91401	illiraiti.		1 🗆		_	robably 4 Unknown	2
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Vital Record	has has ge 2 s	Completed									24a. Was auto	osy	prior to	utopsy findings available completion of cause of	3
a F	cate h											rmed? 2 ☑ No	death?	2 10	
Ĭ.	Icien Certif ector	Be	25. Was case referred to medical examiner?	Hospital:						of Death	(Check only o	опе)			_
	Physicien: The la	- To	1 Yes 2 No  27. Manner of Death	1 LUIP		R/Outpatient		Other	4 🗀 (Vui)				6 ☐Other (Spe	cify)	
2	ling After funer	O	1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	Day Year)	8b. Time of Injury		Work?			8d. Describe	how inju	ry occurred		
S	Attending in death.  ector: After by the fune	ica	2 Accident investigation 3 Suicide 6 Could not be	10	laine At h		М		s 2 🗆 N		0( 1 /				
Division of	or A after Direct in by	Certification:	4 Homicide determined	building,	Injury - At hom etc. (Specify)	ie, farm, stre	et, factory, o	office		2	City or To			ural Route Number,	
_	To the Hospitel or Attending Ph within 24 hours after death, To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Pl	Tysician: To the b	act of multi	odec d		abor el	dat-	l ale -:	and discrete				
	Hos 24 hc Fun stely	edical	(Check only 2 Medical Exal	hysician: To the be miner: On the basis and manner	s oi examinatio	eage, death n and/or inv	occurred at estigation, in	the time my opir	, date and nion, death	n occurre	nd due to the	cause(s date and	) and manner as d place, and due	s stated. to the cause(s)	
	o the	Me	29b. Signature and title of certifier				29c. l	_icense r	number			29d Da	te signed (Mont	h Day Yearl	
1	- ≤ + ŏ		) Onu.	o				02	usa	)		12	_23_5	2004	
	· V	-		completed	of don't //	(2a) /T	N-1-12	20	-(5)				/ _ &		
	54		30. Name and address of person who	teep wo	ueath (Item 2	.oa) (Type, F	rint)	-411	1	6 t	1 AGRA	Sta	2VV- 1.	10 21762	
	Sta	e	31 Date filed (Month Day Year)	32. Red	istrar's Signatur	19	OAK	- CHE	177			-(0		02.17	
	Registra		DEC 27	2004	www so	i pig.	and the							n, Day, Year) 2004 1021742	

State of Maryland / Department of Health and Mental Hygiene 2004 42029 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:44 2004 ec, Gale Altwood KOOGLE /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Name (If not institution, give street end number) Examiner Hagerstown W
If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Yeer) Washington 149 Chantilly Court If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🗘 F Yrs. 220-28-3854 Director Sept. 21 1933 Maryland 71 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at N☐ Yes 2 ☐ No Directo Maryland Washington Hagerstown 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number U.S.A. Funerai 21740 149 Chantilly Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baitimore, Maryland 21215-0020 Specify Completed by 3 Widowed 4 Divorced White natural 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 - 120 Clerk Retail 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) parmit. Peges 1 and 2 should be flik Daportment of Haatth and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumatic event Lillian Brewer Harry Lynn Koogle 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walter L. Hammond/brother-in-law 19605 Portsmouth Dr., Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Rose Hill Cemetery 12/27/04 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 2 Monitor formeres disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medicai Examiner Attending Physician: The law requires that the death certificate be axecuted the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760, Due to (or as e consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 Yas 2THO Records, <u>م</u> 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Be Completed 2 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital filled in by the funeral diractor, 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28e. Date of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Director: After 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours aftar deeth 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner es steted.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) GUORIA 7 36 31. Date filed (Month Percy ear) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 5**:**55a <sup>™</sup> December 19 2004 Armentha /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Cheverly Prince George Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Director 70 228-42-4156 14, 1934 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in then "natural, or items 23a or 28a-f show The Modical Examinational be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Prince George <u>Capitol Heights</u> 10e. Street and Number 10g. Citizen ol What Country? 10f. Zip Code 1207 Addison Road #316 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Emit. Pages 1 and 2 should be filed within 72 hours at Chartment of Health and Mental Hygiens. Importent: If item 27 is marked other than "natural", or I any injury or other traumetic event. Its any injury or other traumetic event. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No Specify: **Black** δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Social Worker</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Jasper Parks, Jr. Marion Louise Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Kirby/Daughter 3517 Pope Street., S.E. Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park \* 4 □ Donation 5 □ Other (Specify) 12/27/04 Landover, Maryland 21. Signature of Funeral Service Licensee Alexander S. Pope Funeral Homes 05 5538 Mariboro Pike, Forestville, MD 23a. Part1. En.e. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, I any, I and I state cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit certificate be executed c Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension, Hyperlipodermia peen 24b. Were autopsy findings available prior to completion of cause of death? Status Post Angioplasty autopsy performed? 2 🗆 No 1 Yes 2**x** No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛛 🗙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicar Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dav. Year) ma D0013231 December 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Pinder, M.D. 3001 Hospital Drive, Cheverly, MD 31. Date liled (Month, Day, Year) 62. Registrar's Signature State DEC 2 2 2004 Registrar

			For State	State of Ma	aryland		artment of h		and Menta		2001	4 42031
			Registrar  1. Decedent's Name (First, Middle, L	ast)			incate of	Dealit		Reg. of Death		3. Time of Death
	Physicia		Robert	Lee	Kil-	gore			Dec	ember	Day Yea	NA NA
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		0	4b. City, Town, o	or Location of			4c. County of D	
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	Funeral			Sex 7. Age 1 ☑ M 2 ☐ F	e (In yrs. las	Vre	If Under 1 Year Months Days		Min. (Mor	of Birth oth, Day, Ye		Birthplace (State or Foreign Country)
	Director		250.01.4653 Usual Residence of Decedent		90	)			Aug.	7, 1	914   Gr	eenville,SC
	how		10a. State 10b. County			Town or Lo						10d. Inside City Limits
	8e-1 s	cto	Maryland Montgon	ery	Silve	er Spi						1 ☑ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number				10f. Zip Code				Citizen of What	Country?
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury go other traumatic event, the Modes Examitted at an and be multilled at ances.		19a. Informant's Name/Relationship				g Address (Street				•	
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			23a. Part . Enter the disease, or co shock, or heart failure. List on	nplications that caused y one cause on each lir	the death.						•	Approximate Interval Between
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Division of Vital Records,									10	performed Yes 2X		
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	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 ☑ Certifying F (Check only one) 2 ☐ Medical Ex-	Physician: To the best on the basis of aminer: On the basis of and manner sta	f examination	edge, deatr n and/or inv	estigation, in my	me, date an opinion, dea	d place, and due th occurred at the	to the cause time, date	e(s) and manner and place, and c	as stated. due to the cause(s)
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	Funeral			. Sex 7. 1  M 2  F	Age (In yrs.		If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, an 18,	Year)	Coun	ace (State or Foreign
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Maryland	2 sho and s me		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Ma	ailing Address	s (Street	and Number or Ru	ral Route Numbe	er, City or Tow	vn, State, Zip	Code)
	1 and 2 Haalth em 27 i		Patricia Fritz -	Daughter	34	Watki	ns F	erry Way,	Martin	sburg,	W.Va.	25401
Sre	of Ha		20a. Method of Disposition		Place of Dis	sposition (Na)	me of	ce)	Date	20c. Location	n - City or To	wn, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Haalth and Mantal Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.		21. Signature of Funeral Service License		riemori	22. Name ar	nd Addre					a
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Division	er de recto	t t	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm,	street, factory	y, office		28f. Location (S City or Tow		nber or Rural	Route Number,
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	hour hour uner	Ca Ca	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	clan: To the best of my kr	owledge, de	ath occurred	et the tir	ne, date and place,	and due to the d	ause(s) and r	manner as sta	ated.
	To the Hospital or Attendin within 24 hours efter death. To the Funeral Director: Att completely filled in by tha fur	edical	one) 2 Medical Examine	er: On the basis of examinand manner stated.	etion and/of	vestigation,	, in my o	pinion, death occur	ed at the time, t	ate and place	e, and due to	ine cause(s)
_	With Tot	₹	29b. Signature and title of certifier					e number		29d. Date sign		
			antha Kut	tree- Sano	Lo, mo			7451				3, 2004
,	11/2	ŀ							15V A	10-th	Acti	zan Street
5	H-2		30. Name end address of person who con Cynthia Kuthner-Sai	Illim ew spu	amspo	-+ Vi	N(1)	a wesom	Mac	land	2179	zan Street 5
	Sta	1	31. Date filed (Month, Day, Year)	32. Registrar's Sign		<i>I</i>		2011/2013	, y	10019	v. I I	
	Registr	ar	DEC 27 20	U4 DECES	D. 1	Bourde	1					

Registrar

11:35 Am

December 23, 2004

Anna Robertson Lance

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene For Stete Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death B. Time of Death Month **Physician** 6:00PM LINTON 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NURSING GLEN 190ME Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🖾 F Months Days Hours Min Yrs. 65 Director 377-38-0959 1939 Detroit, Michiga Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-t show the Medical Examiner must be notified at Prince Georges Maryland Upper Marlboro No Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e 6401 Johensu Drive 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ White Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental h 2 Clara Taranga Emmanuel King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Department of Health a Importent: It item 27 Is any injury or other treuonce. 6401 Johensu Dr., Upper Marlboro, MD Sheri Beach/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 12/18/04 Clinton, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pope Funeral Homes 75538 Marlboro Pike June De 19 Or 18 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORDNARY 4 YRS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death ed by the al detached fo 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate 1 ☐ Yes 2 1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 2 ER/Outpatient 3☐ DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification; 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , SILVER SPRING. HVENUE 209 10301 MEORUNH 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 2 1 2004

DHMH 17 Rev 1/2001

Registrar

			1 - State Registrar	te of Marylan		artment of tificate o			giene 20	04 42035
	Physici		Decedent's Name (First, Middle, Last)     E. Allan Loew					2. Date of De Month Dec 10	Day	Year 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street a Charlotte Hall Veter	ans Home		4b. City, Town Charlo	tte Hall		4c. County o	
	Funeral Director		5. Social Security Number 6. Sex 215 38 4896	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Day		Hrs. 8. Date of Bir Min. (Month, Da May 21	ay, Year)	9. Birthplace (State or Foreign Country) Washington
	Maryland I-f show iled at	tor	10a. State 10b. County Calvert	10c. City	, Town or Lo	epublic				10d. Inside City Limits 1 ☐ Yes 2 ★No
	h with the 3a or 28s	Funeral Director	10e. Street and Number 2323 Acacia Road			10f. Zip Code 206			10g. Citizen of Wh United St	-
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event. The Medical Exercition could be notified at once.	þ	1 Never Married 2 Married 1X	s Decedent Ever in U. ned Forces? ]Yes 2 \( \sum_{No} \) es, Give ar or Dates:		Vas Decedent of Yes, specify C		? (Specify Yes or No uerto Rican, etc.)	14. Race Black, Specify	- American Indian, White, etc. ite
21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade comp	lege (1-4or 5+)	(Give l	OO NOT use reti	ne during most of	•	16b. Kind of Bus	Government
Maryland ?	2 should be filed of and Mental Hygic Is marked other raumatic ovent.	To Be C	17. Father's Nam <i>e (First, Middle, Last)</i> Edgar Allan Loew				18. Mother's Mir.	Name (First, Middle, Inie R	Maiden Sumame, ehfeld	)
	and 2 sho salth and n 27 Is ma er traums		19a. Informant's Name/Relationship (Type, Pri Mary M. Loew - wife	nt)	19b. Mailin 6200	g Address (Stre Oregon	et and Number o Ave. NW	r Rural Route Numbe Washingto	er, City or Town, Si n DC 200	tate, Zip Code) 15
altimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		20a. Method of Disposition 1 □ Burial 2 □ ★ remation 3 □ Remova 4 □ Donation 5 □ Other (Specify)	I from State	emetery, crem	sition (Name of hatory or other p tan Fun		14 2004 vice		ity or Town, State ia Virginia
Balt	permit. Depart Import any inj 2000e.		21. Signature y Funeral Fervice Licensee	C				Rausch Fun and Road P		e blic MD 20676
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause immediate Cause (Final disease or condition	that caused the death se on each line.					rrest,	Approximate Interval Between Onset and Death
ı	/Medical Examiner	_	Sequentially list conditions b.	ue to (or as a consequ	ience of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequ						
P.O. Box 68		Physician/Medical	in the past 12 months?	es, outcome of pregna. Live birth 2 Fetal Pregnant at time of de Unknown	death 3 🗌	Ectopic pregnar Other (specify)			23d. Date Month	,
	The law requires that the ate has been signed by the bage 2 should be detached.		Part II. Dther significant conditions contribution  DEMENTIA, HYPO 7	g to death but not resu HYROIDIS	-		•	23e. Did to		ute to the cause of death?
Division of Vital Records,		Completed by	PULMONARY DISEA	SE, WEL	GHT C	2055			rmed? prid	ore autopsy findings available or to completion of cause of ath?  Yes 2 No
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospita	1 Inpatient 2	ER/Outpatient	257.004	201	Death (Check only o		(0.1)
ion of	ding After fune	-1			28b. Time of Injury	28c. In		19 Home 5 Residence 1 Residenc	now injury occurred	
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)	To t To t	Σ	29b. Signature and title of certifier  Pull Ton	Julito	in		DS07	7/2	29d. Date signed (	Month, Day, Year)
12	+1		30. Name and address of person who complete	d cause of death (Item	23a) (Type, F	Print)	AR COTTE	HALL	MO	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 14 20	d cause of death (Item  1.0.0.  32. Registrate Signate  104	ure J.	Sperke				

Dhuais '		1. Decedent's Name (First, Mid	ldle, Last)	1			rtificat	e oi t	Jeain		2. Date of		ay	Year	3. Time of Deat
Physici Medio/		SHMAEL		LATI							Decemb	er 1	9,	2004	5:21 p.
Examir	ner	4a. Facility Name (If not instituti			er)		_		Location	of Death				ounty of De	
uneral		Citizens Nursi 5. Social Security Number	6. Sex	7.	Age (In yrs.	last birthday)	If Under		CK If Under	24 Hrs.	8. Date of (Month,			ederic	CK irthplace (State or Fore Country)
irector	1	338-01-3560 Usual Residence of Decedent		M 2□F	104		Months	Days	Hours	Min.	(Month, Decemb				Arkansas
show	۲	10a. State 10b. Coun	•	. 1.		ty, Town or Lo									10d. Inside City Lim
28a-1	Funeral Director	Maryland Fro	ederi	CK		Freder	10f. Zip	Codo				100.0	- itiza	n of What C	1 Yes 2
3a or	D	2009 Burnside	e Driv	ve				1702						S.A.	Southly !
Items 2	ner	11. Marital Status	12	2. Was Decede Armed Force			Was Deced	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or Rican, etc.)	No-			nerican Indian,
"natural", or items 23a or 28a-i show edical Exactiver man be redified at	by Fu	1 ☐ Never Married 2 ☐ ★ 3 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes 2 If Yes, Give Year or Date	No.		1 ☐ Yes		Specify:		110411, 010.)		S	pecify: 1	
"natur	Completed by	15. Decede (Specify onfy high	ent's Educa	ation completed)		(Give	dent's Usua kind of wor	rk doné d	lurina mos	t of work	ing	16b.	Kind	of Busines	s/Industry
the Me	id m	Elementary/Secondary (0-12)	)	College (1-4d	or 5+)	wareho	DO NOT us	se retired	)			foo	a.	produ	202
ent,		17. Father's Name (First, Middle	e, Last)			1			18. Mothe	er's Nam	e (First, Mid			<del>-</del>	CEI
	To Be	Charles Lati	more						C	ynth	ia Jo	nes			
7 Is marke traumatic		19a. Informant's Name/Relation		•							al Route Nu				
item 27 other tr	1	Edward Johnson	n – G1	randson		-			Driv			_			d 21702
		20a. Method of Disposition  1		moval from Sta	ite C	Place of Dispo cemetery, crei	matory or o	ther place			Date	20c.	Loca	tion - City o	r Town, State
Important: If any injury or once.	1	* 4 □ Donation 5 □ Other ( 21. Signature of Funeral Service		<u> </u>		ade Cer					-2004	Wa	1k	ersvi.	lle, Maryl
an p		Show out	Bn	in C	allon	0 1		u Addies	S OI F acilii	"Sta	uffer	Fune	ra	1 Home	e ryland 217
	t 1	shock, or neart tailure. Li	st only one	cause on each	n line.	h. Do not ent	ter the mode	e of dying	, such as	cardiac	or respirator	y arrest,		K. Ha.	Approximate Interval Between
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			1 - For State of Maryland / De Registrar		artment tificate			nd Me		gien Reg. No	200	4 42037
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)     Peggy Stewart Ligocki      Aa. Facility Name (If not institution, give street and number)		4b City T	own or	Location of		2. Date of Dea Month Decemb	er	19, 200	14 2:12 A. M
	Examir	ier	2502 Driftwood Court			der		Death		40	Frede	
	Funeral		5. Social Security Number 6. Sex X 7. Age (In yrs. last birtho		If Under 1		If Under 2 Hours	24 Hrs. 8	Date of Birti (Month, Day	h v, Year		irthplace (State or Foreign Country)
	Director		212-24-5712 1 M 2LIF 76 Yr. Usual Residence of Decedent	s.					March	1,1		ryĺand
	ryland how	_	10a. State 10b. County 10c. City, Town of	or Loc	cation							10d. Inside City Limits
	he Ma Ba-f	ecto	Maryland Frederick	F	'reder							1X Yes 2 □ No
	a or 2	급	10e. Street and Number 2502 Driftwood Court		10f. Zip 0		21702			_	itizen of What ( ted Sta	,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f ehow aumatic event, the Medical Evert and must be rodified at	by Funeral Directo	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  If Yes, Give  Year or Dates:		Vas Decede Yes, specif		spanic Orig n, Mexican, Specify:	in? (Spec Puerto Ri	fy Yes or No- can, etc.)		14. Race - An Black, Wh Specify:	
20	72 hou	ted	15. Decedent's Education 16a. Decedent's Education 16a. Decedent's Education 16a. Decedent 16a. Dece	eced	ent's Usual	Occupa	tion	- 6		16b. K	(ind of Busines	s/industry
2	ne. han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	fe. D	kind of work O NOT use	retired)	uring most	of working		TIC	Govern	mant
2	filed v Hygie other t		12 Sec	re	tary		18. Mother	's Name (	First, Middle,			ment
/lan	uld be Mental irked o	To Be	John Hallar Stewart						Topper	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· Cumamo,	
Mar											or Town, State,	
e,	1 and Health em 27		- Ld					ct, F	-		MD 217 ocation - City of	
E E	Pages nent of int: If its iry or o		20a. Method of Disposition  1  Burial 2  Coremation 3  Removal from State  4  Donation 5 Other (Specify)  20b. Place of Disposition  cametery, Frederi					2/21/				Maryland
Baltimore, Maryland 21215-0036	pernit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee  Marianneth Stauffer		Name and		of Facility	Sta	uffer		eral Ho rick, M	me D 21702
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	ente	r the mode	1	- 1		espiratory arr	est,		Approximate Interval Between
	Priysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	AL	and the same of th	12	Chev	Mia				U DUV S
	Examiner		Due it (or as a consequence of:		Live	0	auce	13				www.
	pe iis	iner	Securities list on the is fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury		O at VII	9	u or co				-	
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last  C									-
9/9	certificate be executed Iding physician and Ise as the burial-transit	dlcal E	d									
200	ing phy a as th	ā -	IF FEMALE:									
X Q Q	w requires that the death certific been signed by the attending p should be detached for use as t	lan/M	23b. Was decedent pregnant in the past 12 months?		Ectopic preg						23d. Date of de Month	nlivery Day Year
j.	the de	hysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 🗀 (	Other (spec	irty)						July 102.
ώ T	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	e und	derlying cau	ise giver	n in Part I.		23e. Did tob	pacco t	use contribute t	o the cause of death?
ecords,	require een si rould I		Cancer Capteria						1 □ Y€	es 2	□No 3 □ P	robably 4 Únknown
r	The lay ate has page 2	Completed						_	24a. Was a autops perform	ned?	prior to death?	utopsy findings available completion of cause of s 2 \(\simegap\) No
	Physician: this certificanal director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa						Check only on			
0	g Phy ier this neral d		27. Manner of Death 28a. Date of Injury 28b. Time	e of		. Injury a	at	sing Home 28d	5 🗶 Reside I. Describe ho	ow injur	6 Other (Spery occurred	ecity)
SIO	eath. or: Aff	catlo	2 Accident investigation	у	М	Work?	s 2□No	0				
DIVISION	al or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	stree	et, factory, c	office		28f	Location (St. City or Town	reet an n, State	d Number or R	ural Route Number,
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath (	occurred at estigation, in	the time my opin	, date and prion, death	place, and occurred	due to the ca at the time, da	ause(s) ate and	and manner a I place, and du	s stated. e to the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier  A Z HECAZIVIVO			icense	1,1/	4			se signed (Mon. 2 - 20 -	oil l
١	0		30. Name and address of person who completed cause of death (Item 23a) (Typ. A. Z. TEGTZI 46 B T Novas job 31. Date filed (Month, Day, Year)  DEC 2 0 2004	00, P	rint) So~ D	ric	e, F.	reder	ich M	102	21702	
Ì,	Stat Registra		31. Date filed (Month, Day, Year)  DEC 2 0 2004	635	a franch							

		4	For State	Stat	te of M	arylar	id / D	epai	rtment of	Health a	and Me	ental Hy	giene	2004	1 42	038
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Physi	ciar	_	1. Decedent's Name (First, Middle									2. Date of De Month	Day		1	of Death _ P M
/Med			Ludvic George I  4a. Facility Name (If not institution.		nd number	)			4b. City, Town,	or Location		ecembe		County of De	1	3 * '"'
Exam	nine	r	Holy Cross Hos		io manibor,								40.			
Funera	al			6. Sex	7. A	ge (In yrs.	last birth		If Under 1 Yea		24 Hrs. 8	B. Date of Bir		Montgo 9. B	irthplace (State	or Foreign
Directo			335-07-0872	1 <b>☆</b> M 2	]F	94	4 Y	rs.	Months Days	Hours	Min.	(Month, Da ug. <del>-6,</del>			country) .nnesota	1
pu *		-	Usual Residence of Decedent  10a. State 10b. County			10c Cit	ty, Town	or Loc	ation						10d. Inside (	Pih. Limite
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the N	1	<u>ي</u>	Maryland Mont	gomery			Silv	er	Spring			7	10a. Citi	zen of What (	Country?	
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death ms 2:	8	runerai	11. Marital Status	12. Was	Decedent	Ever in U		13. W	as Decedent of	Hispanic Ori	igin? (Spec	ify Yes or No	)-	14. Race - Ап	nerican Indian,	
after or its	بُ	2	1 Never Married 2 Marri	ed 1 🗌	ed Forces' Yes 2x∏ es, Gîve				Yes, specify Cu			ican, etc.)		Black, Wh		
ours ours	3	ρ α Β	3 Widowed 4 Divorced	Yea	r or Dates:			11	□Yes 2⊡ <b>x</b> No	Specify:				Specify: Wh	ite	
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withir sne.	1	E C	Elementary/Secondary (0-12)	Coll	ege (1-4or	5+)		_	O NOT use retir	90)					~	
Hygin Hygin and, I	3	۔ و	17. Father's Name (First, Middle, I	.ast)			L	77.1	neman	18. Mothe	er's Name (	First, Middle			Company	<u>'</u>
lid be lental ked c	0	0	Fred Lah							Ma	ry Ma	ckovec	:			
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itams 23e or 28e-1 show sumatic event, the Medical Eventual retributes the modified Eventual retributes the modified at	T,		19a. Informant's Name/Relationsh	ip (Type, Prin	t)		19b.	Mailing	Address (Stree	and Number	er or Rural	Route Numb	er, City o	r Town, State,	Zip Code)	20906
and 2			Josephine A. Pu	tman /	Daugh	ter	365	51 Sc	outh Leis	re Wor	ld Blvd	, Bldg.	16-1	C. Silve		
of He ritan		1	20a. Method of Disposition 1 □ Burial 2 ☎ Cremation	3 □Removal	from State		Place of learning	Disposi , crema	ition (Name of atory or other pl		ecemb	te		cation - City o		
Pag ment ant: I	0		`4 □Donation 5 □ Other (Sp		- Otate	, N	Metro Crei		litan orv	i	20	04	Alex	andria	, Virgi	nia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-1 show any injury or other traumatic event, the Medical Exact is very intal be modified at	once.		21. Signature of Funeral Service L	icenses	)			Fra 500	Name and Add INC1S J Unive	ess of Facili COII Sity	ins F	uneral W, Si	. Hom	e Inc	a. MD 2	0901
NE ST			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications	that cause	d the deat	h. Do n								Approxima Interval Be	ate
Physicia	n	И	Immediate Cause (Final disease or condition												Onset and	
/Medica		П	resulting in death)	-	ue to (or a		luence o	f):								
Examine			Sequentially list conditions,	b	. ,											
ed sit	- 1	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events	, D	ue to (or as	s a conseq	luence o	r):								
xecut and	5	Xan	that initiated events resulting in death) Last	c	ue to (or as	a conseq	neuce o	f):								
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burfal-transit	1 2	alcal		d												
ifficating phy as the		D -		1									- 1			
that the death certification of by the attending problem of the attending problem of the transfer of the trans	W/W/	rnysician/m	IF FEMALE: 23b. Was decedent pregnant		s, outcome Live birth			3□E	Ectopic pregnan	CV			1 2	23d. Date of de	,	
he att	30	200	in the past 12 months? 1 ☐ Yes 2 ☐ No	4	Pregnant a Unknown				Other (specify)					Month	Day	Year
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ne lav has ge 2 :	1	E										24a. Was autor perfo		prior to death?	utopsy findings completion of	cause of
ysician: The lav	(	2 -	25. Was case referred to medical	1						OC Place	of Dooth	1 Yes		1 🗆 Ye	s 2 No	
/sicia s cert	0	0	examiner?	Hospital:	™ Inpati	ent 2	ER/Out	patient	3□ DOA O	thor	The state of the s	Check only o		S ⊡Other (Sp	ecify)	
ding Phys	1		27. Manner of Death		Date of Inj (Month, Da	ury	28b. Ti		28c. Inj			d. Describe			July 1	
Attanding Pher death.	9	200	1 Natural 5 Pending 2 Accident investig	ation	(77101171) 01	.y . ca.,		jury		Yes 2	No					
r Attu	1	Certification	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		Place of In	jury - At h	ome, fari fy)	m, stree	et, factory, office	)	28	f. Location (: City or To	Street and wn, State,	d Number or F )	Rural Route Nur	nber,
oital or urs aft rai Dii							2.1 (1.11)									
To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	i i o	edicai		xaminer: On		of examina			occurred at the estigation, in my							s)
To 1 withi To 11		3	29b. Signature and title of certifier		1				29c. Licer	nse number			29d. Dat	e signed (Mor	nth, Day, Year)	
5			M	2					D3	2332			D	ecember	r 12, 2	004
-			30. Name and address of person v						,							
	State		Suresh K. Gup	ta, M.I	32. <b>Pe</b> gist	301 G	eorg	ria	Avenue,		er Spi	cing,	Md 2	0902		
Regis			DEC 14	2004	Sen	تسما	L	9	Spark	2/						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** December 9, 2004 Loretta Lindsay-Reyes 12:45 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince Georges Sacred Heart Home Hyattsville If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Apr 7, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days Min Hours 373-16-2467 1□ M 20 F Months 1922 Michigan 82 Director Usuel Residence of Decedent the Merylend 10c. City, Town or Location 10d. Inside City Limits 10a Stete 10b County permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylei peperment of Heelth and Mentel Hygiene. Important: if item 27 is merked other than 'natural', or items 23a or 28a-f show any hijury or other traumatic event, in a badical Examine must be notified at 1X Yes 2 □ No Funeral Director Maryland Prince Georges Hyattsville 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 5805 Queens Chapel Road 20782 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. 1 Never Merried 2 Married African Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced American 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Chicago Field Museum Admin. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Blanche Hoagland George Yowell 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Marvin Lindsay Son 3910 Commander Drive, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/15/04 Brentwood, Maryland 22. Name and Address of Facility McGuire Funeral Service 21. Signeture of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Cancer of Colon Examiner Due to (or es a consequence of) Examine or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): page 2 should be deteched i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Ĭ Unknown End Stage Alzheimer's disease Completed by 24b. Were autopsy findings avaitable prior to completion of cause of deeth? 24a. Was an autopsy performed? has 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No : After this certificed a funeral director, p Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28e. Date of tnjury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Neturel 5 Pending within 24 hours efter deeth.

To the Funeral Director: Af completely filled in by the fu 1 Tes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 🖄 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner es stated. edicai 29a. Certifier 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number D 51520 12-10-04 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave. S.E. Ste. 310 Wash. D.C. 20032 31. Date filed (Month, Day, Year)
DEC 1 4 2004 Registrer's Signature State DEC Registrar

			1 - For State Registrer	State of Marylan	nd / Depa		lealth and		/giene Reg. No.		4204
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     ALD     AE Facility Name (If not institution, give seems)		L	1 PMAN 4b. City, Town, o	or Location of De	2. Date of De Month DECEMB	ER 11	Year 2004 County of Death	
	Funeral Director	lei	THE JOHNS HOPKINS H.  5. Social Security Number 6. Sev. 261-72-8932	7. Age (In yrs.	last birthday) 52 Yrs.	BALTIMO	RE CITY		rth av. Year)	9. Birth	place (State or Foreig intry) York
0	z should be hied within /2 hours affer death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23e or 28e-f show aumatic event, I'ld Mardical Examinal must be netified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgom  10e. Street and Number  1407 Red Oak Drive  11. Marital Status  1 \( \text{Never Married} \) 2\( \text{Married} \) Married	ery	.S. 13.	ver Sprin	0910 dispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Unit	en of What Cou Ced Stat 4. Race - Ameri Black, White Specify: Wh	CES ican Indian, , etc.
Mai y iai iu 2 12 13-0030	iled within 72 hours fygiene. her then "natural", ht, the Mudical Exa	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	Year or Dates:	16a, Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of v d)		16b. Kind	of Business/Ir	
al ylair.	snould be it and Mental F s marked of umatic ever	To Be	Marvin Lipman 19a. Informant's Name/Relationship ( <i>Ty</i> ,		19b. Mailir	ng Address (Street	Blane and Number or	Name (First, Middle che Reiss Rural Route Numbe	er, City or	Town, State, Zij	p Code)
ב ני	l and Health Iam 27 other tr		Leah Lipman, Wife  20a. Method of Disposition  1公 Burial 2 □ Cremation 3 🖾 R  4 □ Donation 5 □ Other (Specify)		Place of Dispo emetery, crer	sition (Name of natory or other place	ce)	lver Spri Date 2/13/04	20c. Loca	ation - City or T	own, State
1	Department of Important: If it is any injury or once.		21. Signature of Firm of Service Licerse  23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	$\rightarrow$	2.5	4 Carrol	1 St. 1	Funeral	ngton	, DC 2	20012 Approximate
	hysician and // Medical cxaminer the private ransit the private ransit ransi ra	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Fisas Underwing Cause (Disease or injury that initiated events resulting in death) Last	GRAM NG4A Due to (or as a consequ	uence of):	N 1996 I L					Interval Between Onset and Death ( DAY
	y the attending phys ched for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	Ideath 3 [	Ectopic pregnancy Other (specify)	,		236	d. Date of delive	ery Day Year
14 0000000	as been signed by the 2 should be detached	þ	Part II. Other significant conditions con MULTIPLE MYELON		ulting in the ur	nderlying cause giv	en in Part I.				he cause of death? pably 4 Munknown
į	ate has page 2	Completed						24a. Was autop perio 1 □ Yes	osy ormed?	24b. Were auto prior to co death? 1 ☐ Yes	ppsy findings available mpletion of cause of
Attending Ohmer	After this funeral di	Certification: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 SInpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing	eath (Check only on Home 5 Residence Page 1986) Rescribe h	dence 6[		y)
A to lotino	within 24 hours after death To the Funerel Director: completely filled in by the		3 Suicide 4 Homicide  29a. Certifier  Certifying Phys	28e. Place of Injury - At ho building, etc. (Specify ician: To the best of my known	v) wledge, death	occurred at the tin	ne, date and pla	City or Tox	vn, State)	nd manner as s	al Route Number,
Tothotto	1	Medical	(Check only 2 Medicel Examinone)  29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	tion and/or inv	29c. Licens	pinion, death oc	curred at the time,	date and pl	ace, and due to signed (Month,	Day, Year)
12	Sta Registr		30. Name and address of person who con SAMES KIM, M.D., JOHN 31. Date filed (Month, Day, Year)	32. Registrar's Signat	TAL, 60	Print)	JOLFE ST				

			1 - For State Registrar  1. Decedent's Name (First, Middle, Last	State of Maryla	nd / Depa	artment of rtificate of	Health an f Death		Reg. No.	) 4 4 2 0 4 1
	Physic /Medi		SAMANTHA CHRIST	LINE FRE	-			Month DRGMB	Day	Year 1848 PM
П	Examir	ner	4a. Facility Name (If not institution, give				or Location of D	eath		ty of Death
			5. Social Security Number 6. Se		. last birthday)	If Under 1 Year		Hrs. 8 Date of Bin		Comery (State of State of Stat
	Funeral Director		216-21-5680	□M 2 <b>%</b> □F 21	Yrs.	Months Day		Januar	th 1983 y, Year 1983 y 25	9. Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ğ	MD Prince Ge	eorge's	Hyattsv	ille				1 Yes 2 No
	h the	Director	10e. Street and Number	0 -	,	10f. Zip Code			10g. Citizen of	f What Country?
	23e c	alD	4814 Cooper Lane	2			20784		U.S.	. A .
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23e or 28e-1 show event, the Modical Exartinar must be profifed at	by Funeral	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 🕱 N		? (Specify Yes or No uerto Rican, etc.)	- 14. Ra Bla Speci	ace - American Indian, ack, White, etc. ify: Black
1215-0036	n 72 hou "nature	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. Deced	lent's Usual Occi	upation e during most of red)	working	16b. Kind of E	Business/Industry
212	12 should be filed within "h and Mental Hygiene." I's marked other then "reumatic event, the Ms.	Somp	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Cle		ө <i>а)</i>		Priva	ate
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Suma	me)
<u>₹</u>	d Men narke	2		ee				nne C. Smi		
Maryland 2	s 1 and 2 should if Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship (T)  Adrienne C Lee	vpe, Print) e/Mother				Rural Route Numbe		
	tem 27 tem 27		20a. Method of Disposition		Place of Dispo	sition (Name of		Date		- City or Town, State
Baltimore,	0 0		1 ☐ Burial 2 ☑ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		-	natory or other pi	' 1	/21/04		
======================================	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licens	11.2	22	. Name and Add				ale Maryland meral Home
α			L.D. Marsi	hall	74	74 Land				11and 20785
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the deane cause on each line.	th. Do not ente	er the mode of dy	ring, such as card	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner	Je .	resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	LIGHTUN	8				
8/60,	cate be executed physician and the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
. Box o	death certifi e attending id for use as	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnan Other (specify)	cy			ate of delivery onth Day Year
cords, r	w requires that the been signed by th should be detache	ed by P	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	derlying cause g	iven in Part I.	23e. Did to	~	tribute to the cause of death?  3 Probably 4 Unknown
Lec	The law ate has b page 2 si	Completed						24a. Was a autop: perfor 1 ☐ Yes	sy med?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 Klo
	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:	·		hor	Death (Check only or		
5	Phys rahis	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatient 28b. Time of	3 DOA	4 U Nursing	g Home 5 Resid		
0	oding th. : Afte s fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) んしゅ	Injury	28c, Inju Wo M . 1	ork? Yes 2 XNo	HANGINE	, ,	160
DIVISION	To the Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: After this certifica completely filled in by the funeral director,	Sertification;	3 Susuicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre		-	City or Tow	n, State)	ber or Rural Route Number,
	e Hospil 24 hour e Funere etely fille	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, death ation and/or inv	occurred at the t estigation, in my	ime, date and pla opinion, death oc	ice, and due to the c	ause(s) and ma	anner as stated
	To the within To the comple	Me	29b. Signature and title of certifier				se number			ed (Month, Day, Year)
			,	vo. (one)			15236		OFCEMBEL	14,2004
	(6)		30. Name and address of person who co		n 23a) (Type, F REGIC UIU	Print , Ro	anvices M	0 to 852		
	Sta Registr		31. Date filed (Month, Day, Year)  DFC 1 7 2004	32. Registrar's Sign	ature frank	e				

			1 - For State Registrar	State of Maryland	/ Department of F Certificate of		ntal Hygien	CIIIL	42042
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last  SEONG HE  4a. Facility Name (If not institution, give	E LEE	4b City Town o	-	DECEMBER	Year  18 2004  c. County of Death	3. Time of Death 7. 50 AM
	Examin Funeral Director	er	15 PIPESTEM  5. Social Security Number 6. Se	CT	POTO	MAC If Under 24 Hrs. 8. Hours Min.		MONTGON 9. Birthe	MERY  place (State or Foreign  oth)  Korea
	Maryland a-f show	ctor	10a. State 10b. County  MD MONTG		Town or Location			1	0d. Inside City Limits
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Madical Example of Indiffical at	eral Director	10e. Street and Number  15 PIPESTEM  11. Marital Status	2T 12. Was Decedent Ever in U.S.	10f. Zip Code  20	854 dispanic Ofigin? (Specif	(	Sitizen of What Cour	KOREA
5-0036	ours after d	d by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cub	an, Mexican, Puerto Ric	an, etc.)	Black, White,	etc.
21215-0	filed within 72 h Hygiene. ther than "natu int, its Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire:	during most of working d)	16b.	PRIVAT	-
aryland 2	ould be filed I Mental Hygid narked other natic evant, II	To Be C	17. Father's Name (First, Middle, Last) YOUNG MUK	21 N		18. Mother's Name (F	EvI	CHOI	
Z	i and 2 sho Health and tem 27 is my		19a. Informant's Name/Relationship (T)  DAE LEE H  20a. Method of Disposition	USBAND 20b. Pla	19b. Mailing Address (Street  15 PESTER  ace of Disposition (Name of	n et, Pot	DMAC	or Town, State, Zip  MD 20  Location - City or To	0854
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28a-f show amy injury or other traumatic evant, Ite Madisal Examination in at the indifficial and once.		1 Burial 2 Cremation 3 5 Other (Specify, 21. Signature of Funeral Service Licens	Hemoval from State	LY SEMINARY 22. Name and A dre	CROSS 12 THE	RLES H	ARDEN INDS FUN PER MARI	IERAL SERVICE
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o immediate Cause (Final disease or condition	ications that caused the death. ne cause on each line.	Do not enter the mode of dying the Curry				Approximate Interval Between Onset and Death Warner
8760,	Medical Examiner whysician and the purial-transit	ical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque  Due to (or as a conseque  C. Right hem  Due to (or as a conseque  C. Or as a conseque  Due to (or as a conseque  d.	ence of):  ance of):  Viparesis	e Brain	and Bo	one f	ew months
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 □Ectopic pregnanc	У		23d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not result	iting in the underlying cause giv	ven in Part I.	23e. Did tobacco	use contribute to the	
al Records,	ding Physician: The law re h. After this certificate has be funeral director, page 2 shc	Completed					24a. Was an autopsy performed? 1 Yes 200	prior to co death?	psy findings available impletion of cause of 2 No
of Vital	Physician: this certificatal director, I	To Be	25. Was case referred to medical examiner? 1  Yes 2 No		R/Outpatient 3 DOA	26. Place of Death (Coner. 4 Nursing Home	3 /	6 □Other (Specif	(y)
Division o	or Attending Platter death. Diractor: After thin by the funeral	Certification:	27. Manner of Death  1 Natural 5   Pending investigation  3   Suicide 4   Homicide 6   Could not be determined	(Month, Day Year)	ne, farm, street, factory, office	y at	Location (Street a City or Town, Sta	and Number or Rura	al Route Number,
	To the Hospital or Attenwihin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier Certifying Phyone) Certifying Phyone	sicien: To the best of my know iner: On the basis of examination and manner stated.	rledge, death occurred at the ti on and/or investigation, in my o	me, date and place, and ppinion, death occurred	d due to the cause( at the time, date a	(s) and manner as s nd place, and due to	tated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	, Car	29c. Licens			Date signed (Month,	
2	(4)		30. Name and address of person who c		23a) (Type, Print)	Chu co	Mi	Shand	6 2004
	Sta Regist		31. Date filed (Month, Bay, Year) DEC 2 0 2004	3 Registrar's Signatu	Sporter	swe sp	my (+) ()	~~/00	

			For State Registrar	State of M	laryland	d / Depa <i>Cer</i>	artment of <i>tificate o</i>	Health and f Death	Mental Hyg	giene2	004	420	)43
	Physicia		Decedent's Name (First, Middle, Last     Pauline	st)	Rutl	h	Lutz		2. Date of Dea Month Decemb	Day	Year 2004	3. Time of I	
П	/Medic Examin		4a. Facility Name (If not institution, give	e street and number	-)		4b. City, Town	, or Location of Dea			unty of Death	2202	
			Memorial Hosp					mberland			Allegar	ıy	
*	Funeral Director		5. Social Security Number 6. S 220 - 10 - 9263	ex 7. A □ M 2 ☐ F	.ge (In yrs. Ia	ast birthday) Yrs.	If Under 1 Yes Months Day	ar If Under 24 Hr		r, Year)	Cour	lace (State or try) Virgi	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City.	, Town or Lo	cation				1	0d. Inside Cit	v I imits
	Maryli e sho	tor	MD Alle	gany			berland					1 ☐ Yes	
	h the	Director	10e. Street and Number				10f. Zip Code	)		10g. Citízen	of What Cour	itry?	
	23a c		12104 Bedford	Road				21502		U	JSA		
	er dea	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13. V	Vas Decedent of Yes, specify C	of Hispanic Origin? ( uban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14.	Race - Americ Black, White,		
326	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates			I□Yes 2ሺN	lo Specify:		Sp	ecify: W	hite	
Ď.	72 hou	ted	15. Decedent's Ed (Specify only highest gra				lent's Usual Occ	cupation ne during most of w	vorking.	16b. Kind o	of Business/Ind	dustry	
2	ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT use ret	ired)	Orking				
22	iled w Hygier thar tl		1.2 Tather's Name (First, Middle, Last)			Hoi	memaker	18 Mother's N	ame (First, Middle,		nemaker		
Maryland 21215-0036	id be f ental H ked ot c eval	To Be	Unknown		Wolfor	·d		Zelda			Unknow	n	
ary	shou and M s mar	-	19a. Informant's Name/Relationship (						Pural Route Numbe				
Σ,	and 2 ealth a n 27 is		Marvin Lutz / ne	phew				ord Road,	Cumberla				
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heatih and Mantal Hygiene. Intent of Heatih and Mantal Hygiene. Int: If team 22 is marked other than "natural", or Itams 23s or 28s-f show int: If team 22 is marked other than "natural Examiner must be notified at my or other traumatic evant, the Medical Examiner must be notified at		20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 2)		e ce	metery, cren	sition (Name of natory or other p	al Park 1	Date		on - City or To Angeles		
a E	permit. Page Department of Important: ff any injury or once.		21. Signature of Funeral Service Licer		~ HI	22	. Name and Add	dress of Facility A	Adams Fam	ily Fu	uneral	Home,	P.A.
<u> </u>	Per Im		Kalut C. F.	du 1			404 Dec	atur Stre	eet, Cumb	erland	d, MD	21502	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed he death. Tine.	. Do not ente	er the mode of o	lying, such as cardi	ac or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	rdial		ction				i	mmedia	
	Examiner			Due to (or a	s a consequ	ence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequ	ence of):							
	ecuted ind transii	Examiner	Cause (Discass of Figure that initiated events resulting in death) Last	c		-							
8760,	cate be executed physician and the burial-transit	al Ex	resulting in deathy case	Due to (or a	s a consequ	ence of):							
687	ficate physics the	edical	4	d									
Box	eath certific attending p for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregna	BOY		23d.	Date of delive	,	
o. m	e deat he att	Physician/Me	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4☐Pregnant :			Other (specify)				Month	Day Yo	ear
٦.	that the de od by the detached	Phy	Part II. Other significant conditions of	ontributing to death	but not resul	lting in the ur	nderlying cause	civen in Part I.	23e. Did to	bacco use o	contribute to th	e cause of de	ath?
Records,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	d by							1 □ Y	es 2 □ N	o 3 Prob	ably 4 🖔 Ur	nknown
O O	aw requis been 2 shouk	Completed							24a. Was a	an 2	4b. Were autor	osy findings a	vailable
-		Com							autop perfor	med? 2 No	death?		use or
Vital	sicien: Th certificate irector, pag	Be (	25. Was case referred to medical examiner?	Manian					eath (Check only or	ne)			
o	Physi this c	. To	1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1 ☐ Inpat		Proutpation 28b. Time of	t 3 DOA	other: 4 ☐ Nursing	Home 5 ☐ Resid			)	
O	ding th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	V	Vork? ☐ Yes 2 ☐ No	200. 00001100 11	OW III JULY OC	curred		
Division of	il or Attandi after death I Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not b	e 28e. Place of II	njury - At hor etc. (Specify)	me, farm, str	eet, factory, office	20	28f. Location (S City or Tow	treet and No	umber or Rura	Route Numb	er,
ā	ital or rs afte ral Dir led in		Thomas and the second s	building, c	oto: (Opecity)	·			0.19 07 101	n, oldio)			
	To the Hospital or Attanding Physicien: whithin 24 hours after death To the Funaral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the bes niner: On the basis and manners	of examinati	vledge, death on and/or inv	occurred at the restigation, in m	time, date and plac y opinion, death occ	ce, and due to the c curred at the time, c	ause(s) and late and pla	d manner as st ce, and due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1.	)		29c. Lice	ense number			gned (Month, i		
	ی		<b>&gt;</b> 8/3	llu Ti	LN,			D17565		Decer	mber 14	, 2004	
	61		30. Name and address of person who Anthony J. Bol					nal Highw	way, LaVa	le, MI	2150	2	
	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signati		1. 1			511.51			
	negisti	aı	DEC 1.5	2004	Myser	~ /	7 An	me Hat					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2014

			For State Registrar		partment of Health and I e <i>rtificate of Death</i>	Mental Hygi <b>ệr</b> <sub>Reg. ۱</sub>	
	Physici /Medic		Decedent's Name (First, Middle, Last)     NORMAN EDWA	RD MORIN S	₹.	2. Date of Death Month December	23 2004 3. Time of Death 2:06 p M
	Examir		4a. Facility Name (If not institution, give s Homewood Retireme		4b. City, Town, or Location of Death Williamspor	t	4c. County of Death Washington
	Funeral Director		211 10 1700	M 2□F 7. Age (In yrs. last birthda 83 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Dec. 7,	9. Birthplace (State or Foreign Country) Mary Land
	Maryland f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Washing	10c. City, Town or	Location illiamsport		10d. Inside City Limits 1 ☐ Yes 2☐ No
	3a or 28a	Il Direct	10e. Street and Number 16505 Virginia A		10/. Zip Code 21795	,	Citizen of What Country?
980	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show he Mudical Examirer must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Amed Forces?  1	Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puert     □ Yes 2☒ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	vithin 72 ho ne. han "natur e Medical I	mpieted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of wor is. DO NOT use retired)	rking	Kind of Business/Industry  ircraft manufacturer
land 2	12 should be filed within 7 n and Mental Hygiene. Is marked other than "r raumatic event, the Mod	To Be Co	17. Father's Name (First, Middle, Last)  Keller Newto			ne (First, Middle, Maid e Viola Mon	len Sumame)
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be nutified at once.	1	19a. Informant's Name/Relationship (Type Nancy Cowden  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Relation 4 □ Donation 5 □ Other (Specify)	daughter 1074 20b. Place of Discemblery, Cedar La	sposition (Name of rematory or other place) nwn Memorial PK. 1:	Williamsro Date 20c. 2-28-04 Hag	ort, Maryland 21795 Location - City or Town, State gerstown, Maryland
Bal	permit Deper Impor any in		21. Signature of Funeral Service License			., Hagersto	own, Maryland 21740  Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (o) as a consequence of):	1.000	on respiratory arrest,	Interval Between
60,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):			
O. Box 68760,	The law requires that the death certificate that has been signed by the attending physoge 2 should be detached for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that s been signed by should be deta	ed by Ph	Part (I. Other significant conditions con	tributing to death by not resulting in the	e underlying cause given in Part I.		o use contribute to the cause of death?  2 4 Unknown
Vital Records,	n: The taw re licate has be r, page 2 sho	Complet	Arture Disi	ACE DYSOR	1AGIA	24a. Was an autopsy performed:	
of	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No H	ospital:  1	ient 3 DOA Other: 4 Nursing H	ath (Check only one)  Iome 5 Residence  28d. Describe how in	
Division	Attending ir death. ector: After by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) Injur  28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 Tes 2 No	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
۵	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Leartifying Phys	ician: To the best of my knowledge, de	eath occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
		Medical	29b. Signature Apprilia of Complex	and manner stated.	29c. License number		Date signed (Month, Day, Year)
5	H-12+1		STEPHEN E-MIC	mpleted cause of death (Item 23a) (Tyr	De. Print) Northern H	u HAC	estain, and
	Sta	ate	31. Date filed (Month Day, Year)	UE. Higgistial a digitatora			7/7/2

DHMH 17 Rev 1/2001

Registrar

			_	State of Maryland / D			•	•	
			1 - For State Registrar		Certificate of			2004	42045
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic Examir	cal	Bobby Dean Moor  4a. Facility Name (If not institution, give str		4b. City, Town, o	or Location of Death	Dec. 18		22:41 M
			P.G. Hospital		Chever	1 v		Prince G	eorges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir		if Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		251-66-6728 Usual Residence of Decedent	63			08-16-	1941	S.C.
	ryland	L	10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
	he Ma 18a-f	Director	MD Prince Ge	eorges Blade	nsburg				1 Yes 2 No
	with the	Dir	10e. Street and Number		10f. Zip Code			g. Citizen of What Cou	ntry?
	death ms 2	Funerai	4911 Monroe Stre	. Was Decedent Ever in U.S.	20710  13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp		ISA 14. Race - Ameri	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nstursi", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examilier must be neitlined at ADGS.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cub		Hican, etc.)	Black, White,	
21215-0036	72 hou	Completed	15. Decedent's Educa (Specify only highest grade	ition 16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation	ina 10	6b. Kind of Business/Ir	ndustry
121	nathin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)			9		
	filed with Hygiene. other than	Co	1 2 t h 17. Father's Name (First, Middle, Last)		Self-Empl	T	e (First, Middle, M	Private	2
lan	Mental Mental arked o	To Be		nknown			a Jeter	,	
Maryland	2 should and Men Is marke sumatic	-	19a. Informant's Name/Relationship (Type	9, <i>Print</i> ) 19b.	. Mailing Address (Street				o Code)
	1 and 2 Health em 27 I		Carolyn Moorman/		11 Monroe				
Baltimore,	iges 1 it of H if ite or otl		20a. Method of Disposition  1 XBurial 2 Cremation 3 Re	moval from State cemeter	Disposition (Name of ry, crematory or other pla	ce)		Oc. Location - City or To	own, State
Ξ	permit. Pag Department Importsnt: I any injury o		*4 □Donation, 5 □ Other (Specify)  21. Signature of Fune al/Service Licensee		rrection	1 2 - 2		linton, I Funeral H	MD
Ba	Depriment any suny		126 Ta	1 te	1722 Nort	h Capit	ol St. :	runeral n NW Wash.	lome DC 20002
			23a. Part1. Enter the diseas , or complice shock, or heart failure. List only	tions that caused the death. Do reause on each line.	not enter the mode of dyin	ng, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	preno	liseone			
	Examiner			Cond ntere	RULT	breau	1		
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to as a consequence	of):	4.4			
_	and I-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	oflonge	greatly			
760,	ate be executed hysician and he burial-transit	caj E		lane Tens					
9	tificate ig phy: as the		0.	y your wine					
Вох	ith certendin tendin or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnanc	y		23d. Date of deliver	ery Day Year
.O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)			MOILLI	Day roal
Δ.	s that I	by Ph	Part II. Other significant conditions control	ibuting to death but not resulting in	the underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
rds	w require: been sig should b	ed b	benju parte	the lypes	toply		1 🗆 Yes	2 No 3 Prot	oably 4 Unknown
Records,	law requ as been 2 shouk	Completed			10		24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
a R	sicisn: The law certificate has t irector, page 2 s						performe	death? ✓ No 1 ☐ Yes	2 No
Vital	Physicism: this certificated director, I	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☑ ER/Ou	tpatient 3 DOA	200	h (Check only one)	ce 6 ☐Other (Specia	
of	ding Phys h. After this funeral di	H-	27. Manner of Death	28a. Date of Injury 28b. T	Time of 28c. Injury	-	28d. Describe how		y/
Sior	Attending F r death. ector: Atter by the funera	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day You'y		Yes 2 □No			
Division	I or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
_	To the Hospitsl or Attent within 24 hours after deatl To the Funers! Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowledge or: On the basis of examination and and manner stated.	, death occurred at the ti d/or investigation, in my o	me, date and place, opinion, death occurr	and due to the cau red at the time, dat	ise(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier ,		29c. Licens			d. Date signed (Month,	
			ISA RI	M.D	DO	05414	0 12	2/20/06	(
0	(5)		30. Name and address of person who com		(Type, Print)	cl Hann	Too	2/20/04 chered	10 100
			Shervin Rahma 31. Date filed (Month, Day, Year)	2. Registrar's Signature	H.C 30	1 11 ogn	NW 1/1/4	CHEI	YONID
	ີ Sta Registi		DEC 2 1 2004	2. Registrar's Signature	Small				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () For Pegistra MEND ITEM #!&,!\*&19a PER FH @8390 PER FH #14 6/ De auth 2. Date of Death **Physician** Year -57 GL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Severn 8312 Flintlock Court Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 3, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Elberton, GA. **Funeral** Days Hours Min. 1935 1 ☐ M 2 X F 69 410-56-5396 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at Severn Maryland | Anne Arundel 1X Yes 2 ☐ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò United States 21144 8312 Flintlock Court 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced "netural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "ne eny injury or other treumatic event, the Media 2008. Elementary/Secondary (0-12) College (1-4or 5+) Childcare Provider Private 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eula C. McGlocklin. Curtis Blackwell EULA C. McCLOCKLIN 2 19a. Informant's Name/Relationship *(Type, Print)*Thornton Lewis Marshall/Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8312 Flintlock Ct., Severn, MD. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran Cem. Dec. 20,2004 Cheltenham, MD. ⁴ 4 □ Donation 5 □ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike 22. Name and Address of Facility Forestville, MD. 23a. Part1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final GNEVERAC (ancer Physician disease or condition mon /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Ulakaowa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Lo 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After ! Certification; 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: filled in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only onel and manner stated 29b. Signature ag 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) JOHN Marsa 115

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
DEC 2 1 2004

ORIGINAL

2. Registrar's Signature

			For State Registrar	State of M	arylan		artment o			•	giene Reg. No.	2001	+ 4204
	Physici	an	1. Decedent's Name (First, Middle,	,						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,	ie McCarth  give street and number)				vn, or Location	on of Death	Decembe		2004 inty of Death	9:00A. M
	LXdiiiii		Holy Cross Hosp					er Spr	_			ontgome	
	Funeral Director		5. Social Security Number 141–30–2175  Usual Residence of Decedent	1. Sex 7. Ag	je (In yrs.	last birthday) 66 Yrs.	If Under 1 \ Months D	ays Hour	der 24 Hrs. s Min.	8. Date of Bir (Month, Da August	th ly, Year) 17,193	9. Birthp Cour 38 New	place (State or Foreign ntry) Jersey
	yland how		10a. State 10b. County	I		y, Town or Lo	cation					1	10d. Inside City Limits
	8e-fs	ector		George's	Lat	ırel	104 7in 04				10a Citizan	of What Cour	1X Yes 2 □ No
	3e or 3	I Dir	10e. Street and Number 501 Main Street	, #222			10f. Zip Co	207	707			ted Sta	•
96	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "naturel; or items 23e or 28e-f show other treumetic event; the Medical Examenations to notified at	by Funeral Director	11, Marital Status  1 Never Married 2 Marrie	If Yes, Give	?		Was Deceden If Yes, specify 1 ☐ Yes 2			ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Wh	
21215-0036	turel',	ed b	3 ☐ Widowed 4 🂢 Divorced  15. Decedent's	Year or Dates: Education	-	16a. Dece	dent's Usual C	ccupation			16b. Kind o	of Business/In	
215	ithin 72 ne. nen "na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	life.	kind of work of DO NOT use i	etired) -		_			
	filed with Hygiene other the		17. Father's Name (First, Middle, La	ıst)		Admin	istrati			C e (First, Middle)			of Maryland
/lan	2 should be f and Mental H Is marked of eumetic eve	To Be	George	Fr	icke			El	izabe	th		S	Sullivan
Maryland	12 should and Men 1s marke reumetic	ľ	19a. Informant's Name/Relationshi Kevin P. McCartl				-			a <i>l Route Numb</i> imore,			
	Pages 1 and 2 ment of Health a ent: If item 27 liury or other tre		20a. Method of Disposition			Place of Dispo	osition (Name matory or other	of	T	Date		on - City or To	
Baltimore,	Page nent of Interior		1 Donation 5 □ Other (Spe		) ]	-	morial (		12/20	/2004	Dunkirk	, Maryl	and
Balt	permit. Pages 1 and Department of Health Importent: if item 27 any njury or other to 2005.		21. Signature of Funeral Service Li	Bagwa	H.	13. 42.	Name and A nold V 100 Pow	Bord der Mi	wardt 11 ko	Funera ad Belt	l Homo sville	P.A. Mary	land 20705
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition			h. Do not en Emboli		f dying, such	as cardiac	or respiratory a	rrest,	10	Approximate Interval Between Onset and Death Sudden
	/Medical Examiner		resulting in death)	Due to (or as	s a conseq	uence of):							
		ner	Sequentially list conditions,	b. Due to (or as	8 d consec	uence of):							
	te be executed ysician and ne burial-transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	s a consec	uence of):							
760,	e be existian existian existian	ical E		d									
68	ing phy as the	Medi	IF FEMALE:										-
.O. Box	that the death certificate be executed of by the attending physician and detached for use as the buriat-transit	Completed by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	death 3	□Ectopic preg □ Other (spec				23d.	Date of delive Month	ery Day Year
Q.	uires that the signed by do detact	y Ph	Part II. Other significant condition	-		-	nderlying cau	e given in Pa	art I.	23e. Did t	obacco use o	contribute to t	he cause of death?
ords	w require been sig should b	ted L	Diabetes Mellitu	ıs; hyperte	nsion	1				1 🗆	Yes 2□N	o 3∏Prob	pably 4 Xinknown
Il Records,	The lar ate has page 2	Comple								24a. Was autoj perfo 1  Yes	psy omed?	tb. Were auto prior to co death? 1 \(\sum Yes\)	ppsy findings available impletion of cause of
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		IEB/0.4		Othor		h (Check only o		04	
of	<u> </u>	n: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time of Injury		Injury at Work?	Nursing Ho	me 5 Resi 28d. Describe			y)
Division	Attending F r death. ector: After by the funer	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ation			М	1 ☐ Yes 2	□No				
Divi	i te	ertifi	4 Homicide determin		itc. (Speci	ome, tarm, st fy)	reet, factory, o	fice		City or To		imber or Hura	al Route Number,
	Hospite 4 hours Funerel	edical C		Physician: To the best xaminer: On the basis of and manner s	of examina								
)	within 2 To the comple	Me	29b. Signatur, and title of certifier	n				icense numb 2332	er			gned (Month, mber 1	Day, Year) 5, 2004
	1		30. Name and address of person w SK Gupta, M.D.					lver S	bring	Marul	or bas	902	
•	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2004 32. Regist	trar's Signa	ature 5	Spa	uls/	11 <u>1</u>	e richt AT	and ZU	<i>5</i> 02	

			4 101	partment of Health and Mental Hygiene	L R
			Hegistrar  1. Decedent's Name (First, Middle, Last)	Reg. No.   Section   Reg. No.	eath
	Physici /Medic		David Lee Mease	December 19, 2004 11:20	АМ
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death	
		•	601 Cornell Road	Aberdeen Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min. (Month, Day, Year) Country)	Foreign
	Director		213 62 0380 54 Yrs Usual Residence of Decedent	Aug. 8, 1950 Maryland	
	yland		10a. State 10b. County 10c. City, Town of	ocation 10d. Inside City	Limits
	a-fs	ctor	Maryland Harford Aberdeen	1 (X) Yes 2	2 □ No
	or 28	Dire	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
	ath w	ral	601 Cornell Road	21001 United States	
	ltams	Funeral Directo	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 NO	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
38	urs af	by	3 Widowed 4 X Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify: Specify: White	
21215-0036	72 hours after death with the Maryland 'natural', or Itams 23a or 28a-f show dical Examiner must be notified at	Completed by		edent's Usual Occupation e kind of work done during most of working	
2	ithin .	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	
2	led w lygier har th		12 Cab  17. Father's Name (First, Middle, Last)	river Transportation	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumetic evant, the Modical Examiner must be notified at once.	Be C	George L Mease, Jr	18. Mother's Name (First, Middle, Maiden Surmame) Willie Jean Burke	
2	shoulk bd Me mark metic	ဥ		ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	is 1 and 2 is 1 health are item 27 is			Willard Drive, North East, Maryland 21901	
ore,	of Hei		nomoton:	osition (Name of Date 20c. Location - City or Town, State smalory or other place)	
<u><u>ä</u></u>	Page nent ant: If		1 Burial 2 X Cremation 3 Removal from State Naverdal	Dec. 22 2004 Newark, Delaware	
Baltimore,	Departit. Importit any inj		21. Signature of Smiral Since Library	22. Name and Address of Facility Crouch Funeral Home	
	70 E 8 9		gallot our	27 South Main Street, North East, Maryland 21	901
В			23a. Parti. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	Interval Betwee	en ath
	Pnysician / /Medical	ÌΫ	resulting in death)	tarction Immedia	£1
þ	Examiner		Due to (or as a consequence of)		
	- 9	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
1	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.		
Ö,	e exe ian a urial-t		resulting in death) Last Due to (or as a consequence of):		
8760,	The law requiras that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medical	d		
9 X	ding g	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	22d Date of delicent	
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?  1	☐Ectopic pregnancy 23d. Date of delivery  ☐ Other (specify) Month Day Yea	ar
P.O.	t the d by the achec	hysi	9 Unknown		
	ras tha signed I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of dea	ith?
ord	w require been sig should t	ted	Diabetes, hypertension	1 Yes 2 No 3 Probably 4 Unk	known
ecc	e faw r has be je 2 sh	Completed		24a. Was an autopsy findings averaged autopsy prior to completion of cause	ailable se of
<u>=</u>		Co		performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	
Vita	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Check only one)	
of	유 두 등	): To	27. Manner of Death 28a. Date of Injury 28b. Tim		
on	Attending Physician: or death. ector: After this certification in the funeral director.	atlor	1 ☑Natural 5 ☐ Pending (Month, Ďaý Year) Inju 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division of Vital Records,	Atter	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	treet, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)	or,
	ital or irs afte rat Dir			, , , , , , , , , , , , , , , , , , , ,	
	To the Hospital or Attending Ph within 24 hours after death.  To the Funaral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examiner: On the basis of examination and/o	th occurred at the time, date and place, and due to the cause(s) and manner as stated.  nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	thin 2 the or the	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
)	6 4 € 4		1 6 4 H 1 40 -	D42232 12/22/04	
	2		30. Name and address of person who completed cause of death (Item 23a) (Ty	. Print)	
_	2		Scott Feeser 2112 Dundalk	Ave, Baltimore, MD 21222	
	Sta		31. Date filed (Month, Day, Year)  32. Begistrar's Signature	£ . at .	
	Registr	ar	DEC 2 2 2004 Server 18	and the second s	

		•	For State Registrar	State of M	/arylan	•	artment of H		nd Mental H	ygiene Reg. N2	004	42049
	Physici /Medio		1. Decedent's Name (First, Middle, Las Pauline Josephine	*	h				2. Date of I Month Decemb	Day	Year 2004	3. Time of Death 7:10P M
	Examir		4a. Facility Name (If not institution, give Vindobona Nursing	Home			4b. City, Town, or Braddoc		hts	Fr	unty of Death ederic	
	Funeral Director		5. Social Security Number 220-30-7635  Usual Residence of Decedent	ex / □ M 2⊠ F	Age (In yrs. I 92	Yrs.	Months Days		Min. Aug 2	25 1912	Cour	place (State or Foreign http) hiladelphia OH
	Maryland e-f show	ctor	10a. State 10b. County  MD Frederi	ck		, Town or Lo		-			1	l0d. Inside City Limits 1⊠Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code				of What Cour	ntry?
9800	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural, or items 23e or 28e-f ahow other traumatic event, the Madical Exercities must be inclifted at	by Funeral	1100 Peach Orchar  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	d Lane # 1  12. Was Deceder Armed Force 1  Yes 2 If Yes, Give Year or Date:	nt Ever in U. s? ☑No		21716 Was Decedent of Hi f Yes, specify Cuba		1? (Specify Yes or Puerto Rican, etc.)	No- 14.	SA Race - Americ Black, White, ecify: Whi	etc.
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) Coflege (1-4c	or 5+)	(Give life. l	lent's Usual Occup kind of work done o DO NOT use retired nsed Prac	during most of ()			of Business/fn	dustry Profession
d 21	2 should be filed within and Mental Hygiene. is marked other than sumatic event, Ire M		1 1. Tather's Name (First, Middle, Last)			TICE	iiseu riac		Name (First, Midd			11016881011
lan	should be nd Mental marked c	To Be	Henry John Silke						r Colin			
lary	2 short and N is ma		19a. Informant's Name/Relationship (7				-		or Rural Route Nun	-		
Baltimore, N	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra <u>once</u> .		Robert E. McIntos  20a. Method of Disposition  1 X Burial 2 Cremation 3 Company  4 Donation 5 Other (Specify	Removal from Sta	ta i	lace of Dispo emetery, cren	sition (Name of natory or other plac	θ)	Date  Date  12/2	20c. Locat	ion - City or To	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service 24 o	VUELZE	Mer	J		illiams	s Funeral Road, Br		k. MD 2	21716
	Frysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	line.	uence of):  UALY  uence of):			N ACC			Approximate Interval Between Onset and Death
O. Box 68760,	I the death certificate by the attending phy ached for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	d	2 Fetaf at time of de	death 3	Ectopic pregnancy			23d	. Date of delive	ery Day Year
Records, P.	The law requires tha cate has been signed I page 2 should be det	Completed by P	Part ff. Other significant conditions o	ontributing to death	n but not resu	ulting in the u	nderlying cause give	en in Part I.	1[	Yes 2 N	4b. Were auto	he cause of death?  pably 4 Unknown  psy findings available mpletion of cause of
Vital		Be C	25. Was case referred to medical examiner?						Death (Check onl	y one)		
of	ng Phys fter this	ation: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation			ER/Outpatien 28b. Time of Injury	28c. Injun Work	4 Nursi		esidence 6 C e how injury o		ý)
Division	el or Attandi s after death. 91 Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At ho etc. (Specify	ome, farm. str /)	eet, factory, office			(Street and N Town, State)	umber or Rura	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in I	edical (	29a. Certifier (Check only one)	ysician: To the be niner: On the basis and manner	of examinat							
	To the within To the comple	W	29b. Signature and title of certifier	w M	9		29c. Licenso	number 2,203 -	7	29d. Date si	gned (Month, 2     0 !	Day, Year)
(	<u> </u>		30. Name and address of person who	completed cause of				Bru	uswick	MD	2171	6
	Sta Regist		31. Date filed (Month, Day, Xear)		strar's Signa	ture	Annally					

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of	Health and <i>Death</i>		iene2004	42050
¥	Physici /Medi		1. Decedent's Name (First, Middle, Last)		RENE MASSE	R		2. Date of Deat Month Decembe	r 16, 2004	3. Time of Death 9:55 P M
	Examir		4a. Facility Name (If not institution, give s 16149 Foxfield-Dee		ad		or Location of De asville	eath	4c. County of Deal Frederic	
1	Funeral Director		102 20 3003	7. Ag	e (In yrs. last birthda) 79 Yrs.	Months Days		frs. 8. Date of Birth (Month, Day, 30,	Year) 9. Birt 1925 Mar	hplace (State or Foreign untry) yland
	h the Maryland r 28a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Frederic	k	10c. City, Town or I					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with th	al Dire	10e. Street and Number 16149 Foxfield-Dee	rfield Ro	ad	10f. Zip Code 2178	0	1	Og. Citizen of What Co	untry?
36	772 hours after death with the Maryland *natural', or itema 23a or 28a-f show adical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2411 If Yes, Give Year or Dates:		. Was Decedent of If Yes, specify Cub	oan, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
9500-6121	within 72 hou ene. then *natura	Completed I	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Giv	edent's Usual Occu e kind of work done DO NOT use retire Homemak	during most of ved)	working	16b. Kind of Business/	Industry
ylang z	ld be filed vental Hygie	To Be Co	17. Father's Name (First, Middle, Last) Celvis W. Reddick			Homemak		Name (First, Middle, M	Own Hom Maiden Sumame)	e
saitimore, maryi	Pages 1 and 2 shou nent of Heetth and M ant: If item 27 is mar ury or other traumati	Te	19a. Informant's Name/Relationship (Ty, Mahlon M. Masser (120a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Husband)	20b. Place of Disp commetery, ch Germantov	Foxfiel position (Name of ematory or other play on Ch. of	d-Deerfi	Rural Route Number, Le1d Rd., Date	ascade, Ma:	lle, MD 217& Town, State
Da Da	permit. Depart Imports eny inj		21. Signature of Funerel Service License  23a. Part1. Edier the disease, or complishock, or heart failure. List only or	Quelas)	6	l5 EAST M	AIN STRE	EET, THURMO	RAL HOMES, ONT, MD 21	P.A. 788
8/60,	Physician // // // // // // // // // // // // //	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that inditated events resulting in death) Last	Due to (or as	Luci 1.	east (ail				Interval Between Onset and Death
O. Box 6	ne death certifi the attending hed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of deli Month	very Day Year
rds, F	The law requires that the tee has been signed by the bage 2 should be detached.	ρλ	Part II. Dther significant conditions con MINGLUSSIFF	tributing to death be	ut not resulting in the	underlying cause gr	ven in Part I.		acco use contribute to	
al Records,		Completed						24a. Was ar autops perform 1 \supersection Yes 2	y prior to death?	topsy findings available completion of cause of 2 No
ion of Vital	ding Phys h. After this funeral di	ertification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1  Inpatie 28a. Date of Injui (Month, Da)	y 28b. Time	of 28c. Inju	ner: 4 🗆 Nursing	Home 5 Reside 28d. Describe ho	nce 6 Other (Spec	ify)
DIVISION	To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubul	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	in 24 hou in 24 hou in Fune pletely fil	edical	29a. Certifier (Check only one)  Certifying Physical Certifical Certific	sician: To the best of ner: On the basis of and manner sta	examination and/or i	th occurred at the travestigation, in my o	me, date and pla opinion, death oc	ice, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
(	With Com	æ	29b. Signature and title of certifier	ld (qua	aley cur	29c. Licens	013738-	٤	Od. Date signed (Month	, Day, Year)
1	9		30. Name and address of person who co	cus 4 mg pm	St / Gel	(ys/419	, do, ()	7325		
	Sta Registr		31. Date filed (Month, Bay Year) 1	2004 32. R. 39 tra	ar's Signature	Couls,				

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryland / Dep	partment of Health ertificate of Deat	h and Mo th		ene2001	4 42052
	Physici /Medic		Decedent's Name (First, Middle, Last)     John Rae McGown,	Jr.			2. Date of Death December	Pž, 2003	3. Time of Death 1:37P. M
i	Examir		4a. Facility Name (If not institution, give s Laurel Regional Ho		4b. City, Town, or Location Laurel	on of Death		4c. County of De Prince C	
ı	Funeral Director			7. Age (In yrs. last birthda 71 Yrs.	y) If Under 1 Year if Und Months Days Hour	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, ) NOV. 7, 19	9. B 933 Ne	inthplece (State or Foreign Country) W York
	e Maryland 3a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge	eorge's Beltsvil		-			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th	al Directo	10e. Street and Number 10704 Montgomery F	Road	10f. Zip Code 20705		109	g. Citizen of What ( United S	
036	within 72 hours after death with the Maryland one. than "natural", or items 23a or 28a-f ehow than "Medical Examinational Le molified a	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 Tayes 2 No If Yes, Give Year or Dates: 1953–1956	Was Decedent of Hispanic If Yes, specify Cuban, Mexical     Yes 2      No Special	ican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. White
21215-0036	should be filed within 72 hours after death with the Marylan of Mental Hygiens.  marked other than "natural", or flems 23a or 28a-1 show matte event, the Medical Evaluation interface ovent, the Medical Evaluation interface.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (9-12)	College (1-4or 5+) (Gir	eedent's Usual Occupation re kind of work done during m DO NOT use retired) a Manager	nost of workin	g	Sb. Kind of Busines Departmen	ss/Industry
ğ	e filed Il Hygi other	e	17. Father's Name (First, Middle, Last) John Rae McGown, S	Sr.		other's Name Lizabet	(First, Middle, Ma	aiden Surname)	corn
Mary	ind 2 shou alth and N 27 Is mai		19a. Informant's Name/Relationship (Ty) Barbara C. McGown		iling Address (Street and Num )4 Montgomery	nber or Rural Road E	Route Number, C Beltsvill	City or Town, State Le, Maryl	, Zip Code) and 20705
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		position (Name of ematory or other place) I Veterans Cem	!		oc. Location - City of Octoor	
Balt	permit. Departri		21. Signature of Funeral Service License	Eward I	22. Name and Address of Fac Conald V. Borg 1400 Powder Mi	jwardt 11 Rd.	Funeral Beltsvi	Home, P. 11e, Mar	A. yland 20705
1	Physician /Medical	87 TI	23a. Part 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		t,	Approximate Interval Between Onset and Death 11/12/2004			
8760,	cate be executed xx mphysician and the burial-transit and the burial	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Chronic Obstructi  Due to (or as a consequence of):  Due to (or as a consequence of):	Diseas	e			
Box 6	at the death certific. by the attending place tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
1	as thg gnad se de	þ	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Pa	art I.			to the cause of death?  Probably 4 □Unknown
Vital Records,	The ate h	Completed					24a. Was an autopsy performe	prior to death?	autopsy findings available completion of cause of
	A S	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital: ↑ ☐ Inpatient 2 ☐ ER/Outpati	Other		(Check only one) e 5 ☐ Residen	ce 6 □Other (Sp	pecify)
lon of	tending Physeath. tor: After thi the funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury			8d. Describe how	injury occurred	
DIVISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)			City or Town,	State)	Ru <i>ral R</i> oute Number,
	n 24 hou	edical	29a. Certifier  (Check only one)  Certifying Phys 2 ☐ Medicel Examin	sician: To the best of my knowledge, dener: On the basis of examination and/or and manner stated.	ath occurred at the time, date investigation, in my opinion, d	and place, ar death occurre	nd due to the cau d at the time, date	se(s) and manner a a and place, and du	as stated. ue to the cause(s)
	To the vithin To the compl	M	29b. Signature and title of certifier		29c. License numbe D0013668	er		Date signed (More cember 1.	
	10		30. Name and address of person who co Azher Hussain, M.D		•	rk, Ma	ryland 2	0740	
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	South				

			For State Registrar	State of Mar		epartmen Certificat			and M	ental Hy	giene Reg. No. 2	004	42	053
	Physicia	200	1. Decedent's Name (First, Middle, La							2. Date of De Month	Day	Year	3. Time	
	/Medic		Santina Marie							Dec. 1			6:15	AM M
	Examin	er	4a. Facility Name (If not institution, giv		-			Location o	f Death			ty of Death		
	<b>.</b>		Washington Advent 5. Social Security Number 6.5		a⊥ (In yrs. last birth		1 Year		24 Hrs.	8. Date of Bir		gomer 9. Birtho	y lace (State	or Foreign
	Funeral Director					rs. Months	Days	Hours	Min.	8. Date of Bir (Month, De June 3	y, Year) 0,1916	Cour	1/0/	ryland
	<b>D S</b>		Usual Residence of Decedent		10c. City, Town	or Looption							0d. Inside (	
	shov	70	10a. State 10b. County											s 2 No
	the N	rect	Maryland Prince G	eorges	Hyatts	10f. Zip	Code				10g. Citizen o	f What Cour	ntry?	
	3a or	Funeral Director	5805 Queens Chape	1 Road			20	782			US.	A		
	death	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Dece			gin? (Spe	cify Yes or No	- 14. R	ace - Americ		
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 💥 No If Yes, Give		1 ☐ Yes		Specify:	,	, , ,	Spec		ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Modical Examiner must be notified at		3 Midowed 4 □Divorced  15. Decedent's E	Year or Dates:	16a F	Decedent's Usu	al Occup	ation			16b. Kind of	Business/In	dustry	
15	n na	plet	(Specify only highest gra Elementary/Secondary (0-12)		(	Give kind of wo life. DO NOT u	rk done o	during most	of workir	ng	TOD: IXIIIO OI	# C C C C C C C C C C C C C C C C C C C	333 tr	
212	giene giene er the	Completed	8	College (1-401 3+	<b>'</b>	File C	lerk				Un	ion		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last	,							, Maiden Sum	ame)		
yla	d Men narke	To	Salvatore Balsan		105	Mallia - Addesa	(Ct			e Cappo		- C4-4- 7:-	Codel	
Maryland	d 2 sl th an th an treur		19a. Informant's Name/Relationship ( Gary Balsamo/Gran			Mailing Address					-	rr, State, Zip	(0000)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Modical Examiner must be notified at 2008.		20a. Method of Disposition		20b. Place of I				ec.		20c. Location	- City or To	wn, State	
E	Page Int: If		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special		1	Heave	n Cen	n. ¦	- 20	004	Silver	Sprin	g,MD	
Baltimore,	rmit. poartm porte y inju		21. Signature of Funeral Service Lice	nsee		22. Name a	nd Addres	s of Facility	De V	ol Fun	eral Ho Ave . 2000	ome		
<u> </u>	90E 90		James Els	Obl				Wash	ingto	on, D.C	2000	7		
	20		23a. Sant1. Enter the disease, or comshock, or heart failure. List only	one cause on each line	he death. Do no	ot enter the mod	de of dyin	g, such as — ^/	cardiac o	r respiratory a	rrest,		Approxima Interval Be Onset and	etween
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a Acute	resp	Valory	F	alu	ne			0	no wh	rek
	Examiner			Due to (or as a	consequence of	" PO	مدده	1 1 2574 2	a .				no Hi	c. U
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (r as a	consequence of	):							ne w	
	cuted nd ransit	Examiner	that initiated events	c Sept	tecom	(A							new	leck
30,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (orlas a	consequence of	):								
8760,	physic	dical	•	d										
Box 6	death certifica e attending ph id for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. [	ate of delive	ery	
	death e atter	Iclar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti	_	3 □Ectopic p 5 □ Other (s <sub>i</sub>					N	fonth	Day	Year
P.0		hys	9 Unknown	9□ Unknown						77				
Ś	es be	by	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying of	ause give	en in Part I.		1	obacco use co			
ord	w requir been si should	eted								10			ably 4	
Record	e law has t	Completed								24a. Was autop		. Were auto prior to co death?	psy findings mpletion of	cause of
a	icien: The l certificate ha rector, page	e Co	25. Was case referred to medical					00 01		1 Yes	2 No		2 □ No	
Vital	Physicien: this certificatal director.	0 8	examiner?	Hospital: 1 Inpatient	t 2 ER/Out	patient 3 De	Oth	05		( <i>Check only o</i>	dence 6 □C	ther (Specif	v)	
J Of		T:U	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day			28c. Injun Worl		-		how injury occ			
sior	Attending r death. ector: Afterby the fune	catlo	2 Accident investigation	n		М		Yes 2 □	No					
Division	or Attencater death after death Director:	ertification;	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, fari (Specify)	n, street, factor	y, office		2	28f. Location ( City or To	Street and Nur wn, State)	nber or Rura	il Route Nui	mber,
	Hospitel 4 hours a Funerel [	O	29a. Certifier 1 (V Certifying P	hysician: To the best of	my knowledge	death occurred	at the tin	ne, date an	d place, a	and due to the	cause(s) and r	nanner as s	tated	
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical		miner: On the basis of e and manner state	examination and									(s)
	To the To the To the Complet	Me	29b. Signature and title of certifier	10				e number	y		29d. Date sign			15
}	- 2	)	> MKarry	L.J.				895			Decem			
			30. Name and address of person who MOBARAK KA	21M, 7610	ath (Item 23a) (1 CARR	OLLAV	E, S	TE34	10)	TAKOM	APARK	., MI	200	112
	Sta Registr		31. Date filed (Month, Day, Year) DEC 15 200	32 Registrar	's Signature	doo	A Cord	7						

			1- State of Maryland / Dep	partment of Health and Mertificate of Death		iene OOL	42054
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Deal	th Day Year	3. Time of Death
	Physicia /Medic		John Morris			14 2004	8:30 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Clinton Rehab Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Clinton  (1) If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Prince G	
	Funeral Director		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Days Hours Min.	8. Date of Birth (Month, Day, April 6	Year) Could 1933 Alab	place (State or Foreign intry)
			Usual Residence of Decedent			1933  21245	dind
	arylar show	_	10a. State 10b. County 10c. City, Town or L	_ocation			10d. Inside City Limits
	Ba-f	by Funeral Director	MD Prince George's Temple				1  Yes 2 No
	with t	Dir	10e. Street and Number	10f. Zip Code		Og. Citizen of What Cou	intry?
	ns 23	erai	4420 19th Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13	20748 Was Decedent of Hispanic Origin? (Sp.		U.S.A. 14. Race - Ameri	can Indian
<b>'</b> O	r Item	Fun	1 Never Married 2 Married In Stress 2 No Army	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
036	ret', o	by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🙀 No Specify:		Specify: Bla	ack
5-0	72 ho	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work	ing	16b. Kind of Business/Ir	ndustry
121	within ine. ihan '	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Government	
D	filed v Hygie ther I		12th Sec	urity Officer  18. Mother's Name	e (First, Middle, I		
an	should be filed within 72 hours after death with the Maryland nd Mental Hygjene. It marked other than "naturet", or items 23a or 28a-f show marked other than "naturet", or items 23a or 28a-f show marked other than "Redical Examinar russi Lear cliffed at	To Be	Ashton Morris	Teadie	Orr	,	
ary	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	_		ling Address (Street and Number or Run	al Route Number	r, City or Town, State, Zi	p Code)
Š	and 2 ealth a n 27 is		Tamera V. Yates/Daughter 4511	. 23rd Parkway # 20	3 Temple	e Hills,Mar	yland 20748
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hygiene. If item 27 is marked other than "naturet", or items 23a or 28a-f show or other treumatic event, the Medical Examinat must be rediffied at			ematory or other place)	Date	20c. Location - City or T	own, State
Ĕ	Pag ment ent: h		'4 Donation 5 Other (Specify) Maryland	Veterans 12/21	/04	Cheltenham,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health s Importent: If item 27 li any injury or other tre			22. Name and Address of Facility J 7474 Landover Road		kins Funera er, Maryland	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Pnysician	e y	Immediate Cause (Final disease or condition	tic heart	desc	ax	Onset and Death
	/Medical Examiner		Due to (or as a consequence of)	1 Atla	e 12		
		ī	Sequentially list conditions, if any leading to immediate Due to or as a consequence of):	1100 HILLI		4030	
	uted 1 nnsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	exection and and rial-tra	Еха	resulting in death) Last Due to (or as a consequence of):				
8760,	the death certificate be executed y the attending physician and tched for use as the buriat-transit	dicai	d				
9	artifica ing ph e as th	Med	IF FEMALE:				
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
0.	the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 5	Other (specify)			,
Φ.	res that the de igned by the be detached	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	bacco use contribute to t	the cause of death?
Records,	The law requires that ite has been signed b bage 2 should be deta	d by	End Stage Koul	Deserge	1 □ Ye	es 2□No 3□Proi	bably 4 Unknown
CO	w require s been si should t	iete	Di Dori Copoul	dant	24a. Was a	n 24b. Were auto	opsy findings available
Re	The lav te has age 2	ompieted	- Dear for Cost of the		autops perforr	sy prior to co med? death? 2. X No 1 ☐ Yes	ompletion of cause of
Vital	ien: Trifical	C	25. Was case referred to medical	26. Place of Deat			20110
	Physicien: r this certific ral director,	To B	examiner? 1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpatie	ent 3 DOA Other: Nursing Ho	me 5 Reside	ence 6 Other (Specia	fy)
ם ס	ing Pl		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury (Month, Day Year)	Work?	28d. Describe ho	ow injury occurred	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation	M 1 Tes 2 No	006 1 /04		-10 111
Division of	or Atlanter of Direction by	Certification:	4 Homicide	street, factory, office	City or Town	treet and Number or Rur n, State)	ai Houte Number,
	Hospitel or 14 hours afte Funerel Dir tely filled in b		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the ca	ause(s) and manner as s	stated.
	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	investigation, in my opinion, death occurr	red at the time, d	ate and place, and due t	o the cause(s)
	To the l	ž	29b. Signature and title of certifier	29c. License number		9d. Date signed (Month,	Day, Year)
)			) udh Un Corlin	0004549	70	12/17/0	7
K	(4)		30. Name and address of person who completed cause of death (Item 23a) (Type		1.1	DC 20212	
/[	V		Yudh Gupta M.D. 106 Irving Street  31. Date filed (Month, Day, Year)	N. W. Suite 415 Wa	sningtor	1, DC 20010	
	Sta Registr		DEC 1 7 2004	alle)			

		_	For Stata Registrar		State of N	Marylan	d / Dep <i>Ce</i>	artment of I rtificate of	Health and Death	Mental Hy	gien Reg. N	m	420	55
	Physicia		1. Decedent's Nam							2. Date of De Month		ay Yea	3. Time o	_
	/Medica		Diane	! 	Lee	Mon	tefus			12	14			. <b>5</b> M
	Examine	er	4a. Facility Name (	1	give street and number	or)	10 11.		or Location of Deat	th	4	c. County of De		
			5. Social Security N	1 /-/	NM ///CM/10	A CO	last birthday	If Under 1 Year	1/354M	9 Date of Bi	#b		mico	
	Funeral Director	- 1	057 <b>–</b> 44–22			54	Yrs.	Months Days			ay, Yea 950	r) 9. E	dirthplace (State Country) WYORK	or Foreign
			Usual Residence o							117/2/1	230	TAG	SW TOLK	
	how		10a. State	10b. County		10c. City	y, Town or L	ocation					10d. Inside (	1
	a Ma	ΘM	aryland	Wicom	ico	Paı	rsonsb	urg					1 🔼 Yes	s 2 No
Q	if the series		aryland  10e. Street and Nu  7115 Ti  11. Marital Status  1 $\square$ Never Marr		<b>.</b>			10f. Zip Code			10g. C	itizen of What	Country?	
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$\mathcal{L}$	ltam Itam	nu.	11. Marital Status	ied 2□ Marrie	12. Was Deceder Armed Force 1 ☐ Yes 2 ∑	s?	.5. 13.	If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	0-	14. Hace - Ar Black, Wi	nerican Indian, nite, etc.	
38 7	al', or	by	3 Widowed		If Yes, Give Year or Dates	_		1 ☐ Yes 2X No	Specify:			Specify:	white	
M Dn fe 215-0036	filed within 72 hours after death with the Maryland Hygiene. that then "naturel" or Itams 23e or 28e-f show ent. The Medical Examinating must be notified at	ted	/Page	15. Decedent's			16a. Dece	dent's Usual Occu	pation	rkina	16b.	Kind of Busines	ss/Industry	
ΣË	thin 7	Completed	Elementary/Second		grade completed) College (1-4o	or 5+)			during most of wo	rking	**-	.11 0		
2	led w ygien ygien tar th	ဂ် ပ			-		Nur	ses Aide	T 12 i		1	olly Cer	iter	
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<b>₹</b> ₹	should and Men s marks umatic	2	19a. Informant's N				10h Maili	na Address /Stree	Marie	Klemn	or City	Zio Codol		
$\nabla_{\mathbf{a}}^{\mathbf{Z}}$	and 2 seath an m 27 is in traui	-1			co/ex husb	and				Rural Route Number, City or Town, Sta Elmar, MD 21875			, <i>21p C</i> 00 <del>0</del> )	
ē,	- I = =	ŀ	20a. Method of Dis	position	· · · · · · ·	20b. P	lace of Dispo	osition (Name of matory or other pla		Location - City	or Town, State			
E O	Pagas nent of int: If it				I □Removal from Statectfy)	te Wic	pmico	Memoria]	12/	18/04	Salisbury, MD			
Baltimore	permit. Departm Importa any inju		y4 □ Donation 5 □ Other (Specify)  Wicomico Memorial  12/18/04  23. Signature of Fueral Service Licensee  Wicomico Memorial  12/18/04  24. Name and Address of Facility  Holloway Funeral Home Prof									ofessional Associati		
Ω.	88 5 5		Holloway Funeral Home Profession 501 Snow Hill Rd., Salisbury, MI										Associa 804	tion
	100		23a. Part1. Enter t shock, or hea	the disease, or c art failure. List o	omplications that caus	ed the death line.	n. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Interval Be	itween
	Physician		Immediate Cause disease or condition	(Final on	a .		AS	CVS					Onset and	Death
	/Medical Examiner		resulting in death)	1	Due to (or a	as a consequ	uence of):							
B		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	d insit	Examiner	cause. Enter Unde Cause (Disease or	erlying injury										
/ 0	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Еха	that initiated events resulting in death)	Last	C. Due to (or a	c						-		
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22 2	ntifica ing ph a as th	Med	IF FEMALE:											
300	eath certific attending p	an/	23b. Was deceden	months?	23c. If yes, outcom 1☐Live birth	2 Fetal	death 3[	Ectopic pregnanc	у			23d. Date of d Month		Year
20	the de by the a tached f	Physician/Med	1 ☐ Yes 2 [ 9 ☐ Unknown	■No	4□Pregnant 9□Unknown		eath 5L	Other (specify) _					,	
50€	res that the igned by be detaction.		Part II. Other signi	ficant condition	s contributing to death	but not resu	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did	obacco	use contribute	to the cause of	death?
ds	uires n sign	d by			DM					10	Yes :	2 □ No 3 <del>□</del> 4	robably 4 🗆	Unknown
000	s been sign should b	ompieted			HTW					24a. Was		24b. Were	autopsy findings completion of c	available
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ita		Bec	25. Was case refer	rred to medical					26. Place of Dea	ath (Check only		-		
/ Division of Vital Record	S S E	0	examiner? 1 Yes 2		Hospital: 1 ☐ Inpa		ER/Outpatie	IL 3 LI DOA		łome 5 ☐ Resi			ecity)	
u o	ding P. h. After t tunera	.: 0	<ol> <li>Manner of Deat</li> <li>Matural</li> </ol>	5 Pending	28a. Date of In (Month, I	njury Day Year)	28b. Time o Injury	Wo		28d. Describe	how inj	ury occurred		
isic	or Attending ifter death. Diractor: After in by the fune	icat	2 Accident 3 Suicide	investiga 6 ☐ Could no	t be 290 Place of I	Injuny - At ho	ome farm et	M 1	]Yes 2□No	28f Location /	Stroot	and Number or I	Rural Route Nun	nhar
Σ	after Dirac Jin by	Certification:	4  Homicide	determin	building,	etc. (Specify	()	eet, ractory, office		City or To			TUIAI MODIO IVUII	1001,
			29a. Certifier	1 Certifying	Physician: To the be	st of my know	wledge, deat	h occurred at the ti	me, date and place	, and due to the	cause(	s) and manner a	as stated.	
	n 24 h	edical	(Check only one)	2 Medical E	aminer: On the basis and manner	of examinat	tion and/or in	vestigation, in my	opinion, death occu	irred at the time,	date ar	nd place, and do	ue to the cause(	3)
	To the To the comp	Ž	29b. Signatura and	title Certifier				29c. Licens				ate signed (Moi		
	10			Lend	<u> </u>			H-20	0497		1	2/14/04		
	5 MO	+			no completed cause of	f death (Item	23a) (Type,							
			Or. Chris. 31. Date filed (Mon		C	arroll grar's Signal	St.	Jalisbu	ry MD.	21801				
	State Registra	-	(14/0/	DEC 1	3 2004	repers	2	1 Spai	KN					

			1- State of Maryland 1- State 24a per Verb., G83	/ Depa 39 - 61 <i>Cei</i>	artment of Health and 705/2005dhb rtificate of Death	l Mental Hygi	ene2004 42056						
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year						
	/Media	cal	Frances Ann		Miller	Decembe	er 23, 2004 840am M						
1	Examir	er	4a. Facility Name (If not institution, give street and number) Kline Hospice House		4b. City, Town, or Location of De Mount Airy	atn	4c. County of Death Frederick						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year If Under 24 H Months Days Hours M		9 Birthplace (State or Foreign						
	Director		218-82-5934 1□ M 2□XF 85  Usual Residence of Decedent	Yrs.	The state of the s		1919 Virginia						
	yland		10a. State 10b. County 10c. City, T				10d. Inside City Limits						
•	Be-Is	ctor		reder	ick 		1 ∑ Yes 2 ☐ No						
	ath with the 23a or 2	Funeral Director	253 Wyngate Drive		10f. Zip Code 21701	10	g. Citizen of What Country?						
21215-0036	72 hours after death with the Maryland netural', or Items 23a or 28e-1 show itest Examinat must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White						
5-0	72 hours "netural",	etec	15. Decedent's Education (Specify only highest grade completed)	16a. Decec (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking 16	6b. Kind of Business/Industry						
121	filed within thygiene. other then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		nemaker		Own Home						
b		BeC	17. Father's Name (First, Middle, Last)		18. Mother's N	ame (First, Middle, Ma							
ylaı		To	Edward William		Clift Sevi		- 4.0.0						
Maryland	S S S		19a. Informant's Name/Relationship (Type, Print) Wm Edward Miller/Son		ng Address (Street and Number or								
	s 1 and 2 if Health item 27		20a. Method of Disposition 20b. Plac	e of Dispos	Ball Road, Fre		Cryland 21/04  Oc. Location - City or Town, State						
altimore,				8,2004 F	rederick, Maryland								
Balt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Idensee  MO070	eral Home ck, Maryland 21701									
ant's	* *		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heaf failure. List only one cause on each line.		06 East Church S er the mode of dying, such as card	ac or respiratory arres	t, Approximate Interval Between						
	Physician		Immediate Cause (Final disease or condition a. Stroke resulting in death)				Onset and Death  3 Weeks						
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	ficate be executed physician and is the burial-transit	Examiner	that initiated events										
60,	be exician a		Due to (or as a consequen	ice of):									
68760		edical	d										
P.O. Box	that the death certiff hed by the attending detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 🗆	Ectopic pregnancy		23d. Date of delivery Month Day Year						
	res that igned b	by P	Part II. Other significant conditions contributing to death but not resulting			23e. Did toba	cco use contribute to the cause of death?						
ord	taw requires as been sign 2 should be		Atrial Fibrillation; Coronary Ar	tery	Disease;	1 ☐ Yes	2 ☑ No 3 ☐ Probably 4 ☐ Unknown						
of Vital Records,	The ate h page	Completed	Hypertension; Osteoarthritis; G	.I. k	oleeding	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 \rightarrow Yes \rightarrow \rightarrow No						
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		O4h	eath (Check only one)							
	Phys this ral di	To To	27. Manner of Death 28a. Date of Injury 28	Outpatient b. Time of	Other: 4 Nursing  28c. Injury at Work?	Home 5 ☐ Residence 28d. Describe how	e 6 ©Other (Specify) Hospice						
ion	Attending Ph ir death. ector: After th by the funeral	atior	1 XNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Work? M 1 ☐ Yes 2 ☐ No		,,,,,						
Division	or At fter c Direc in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)						
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. o and place, and due to the cause(s)						
1	To 1 With To 1	Σ	29b. Signature and title of Certifier	the	29c. License number D35183		Date signed (Month, Day, Year)						
•	8		30. Name and address of person who complete cause of death (Item 23 Ali J. Afrookteh, M.D., 300 West	sa) (Type, F	Print)		·						
	Sta					rick, rary	Tail ZI/VI						
	Registr	ar	MIN O S COOD SERVED AS A	JAN 0 5 2005									

State of Maryland / Department of Health and Mental Hygiene 42057 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 7:55 P M MORRIS DECEMBER 12,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PITTSVILLE 35327 WANGO ROAD WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💢 F 77 218-20-9166 Director 06-05-1927 MARÝLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at WICOMICO PITTSVILLE 1 Yes 2 No MD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö death with 35327 WANGO ROAD 21850 USA or Itams 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 2XNo þ Specify: Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than PIECE WORKER CLOTHING INDUSTRY 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM BRADFORD DELLA DENNIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES BRADFORD - NEPHEW 35315 WANGO ROAD, PITTSVILLE, MARYLAND 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 12-16-2004 | POWELLVILLE, MARYLAND JONES CEMETERY 22. Name and Address of Facility 21. Signature of Feneral Service L BOUNDS FUNERAL HOME 705 E MAIN STREET SALISBURY, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 1 29 9 45 /Medical Due to (or as a consequence of) **Examiner** 2 20 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burialphysicien P.O. Box 68760 Physician/Medical the use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ₺ No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed; 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was c s referred to medical examiner? 26. Place of Death Check on one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical 29a. Certifier 1 🔏 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine Horner 76 31. Date filed (Month, Day, Year) DEC 1 4 2004 32. Registrar's Signature State Registrar

Amended # 10b , MLU 12/22/04 Allegany Co.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

cian	1. Dec	egistrar edent's Name	(First, Middle	, Last)	-		rtificate of			2. Date of D Month	Reg. No. eath Day	20		3. Time of De
ical		CLARA	M. M	cKENZIE					I	DECEMB:		1, 20	04	1:05 E
iner	4a. Fac	cility Name (If	not institution,	give street and n	um <i>ber)</i>		4b. City, Town, or	r Location	of Death			County of I		
	Fro	stburg V	illage Nu	ursing Care	Center	. last birthday		rostbu If Under		8. Date of B		egany 9		e (State or F
1 r		1-16-236		1 □ M 2 💢 F	89	Yrs.	Months Days	Hours	Min.	8. Date of B (Month, D			Country	
	Usual	Residence of	Decedent			ity. Town or L	anation.			.,				
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Director		ryland treet and Num	nher	<del>jany</del>		tburg	10f. Zip Code				10g. Citiz	en of Wha		
			1217 F	inzel Road			21532-				U.S.A.			
Funeral	11. Ma	rital Status		12. Was De Armed F	cedent Ever in torces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Or an, Mexica	igin? (Spe	cify Yes or N Rican, etc.)		4. Race Black. \	American White, etc.	
by Fu			ed 2 Marri	If Yes, G			1 ☐ Yes 2 No	Specify:				Specify:		
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à			neral Service L		/		2. Name and Addre	ss of Facili						
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	diseas	diate Cause ( se or condition	Final n	a	Acut	e N	ly o Caro	tial	ruf	evetin	i .			neet and De
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Be Completed by Physician/Medical Examiner	IF FEI 23b. Viii 1 9	MALE: Was decedent in the past 12 Yes 2 Unknown Other significations	t pregnant months? No icant condition	c	o (or as a consecution of or as a consecution of pregration of pregration of pregration of the consecution o	equence of):  nancy tal death 3 death 5 leath	□Ectopic pregnancy □ Other (specify) _ underlying cause giv	ren in Part I	I.	23e. Did 1  24a. Wa aute perl 1 Yes	tobacco us  Yes 2  s an  spsy ormed? 2  No one)	Month se contribu No 3	f delivery Da te to the c Probable e autopsy th? Yes 2	y Yea
To Be Completed by Physician/Medical Examiner	IF FEI 23b. V	MALE: Was decedent in the past 12 Yes 21  as case referraminer? Yes 21	pregnant months? No  red to medical	c	o (or as a consecution of or as a consecution of pregraph birth 2 Felgrant at time of shown death but not recovered.	equence of):  eq	□Ectopic pregnancy □ Other (specify) □ underlying cause giv	ren in Part I	I.	23e. Did 1 □ 24a. Wa aute perf 1 □ Yes (Check only)	tobacco us Yes 2 s an ppsy ormed? 2 No one) iidence 6	Month se contribu No 3	f delivery Da te to the c Probable e autopsy th? Yes 2	y Yea
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edical Certification; To Be Completed by Physician/Medical Examiner	25. W 9x 1[27. Mag 4]	MALE: Was decedent the past 12 Yes 2	red to medical No  S Pendin investig 6 Could n determi	C	o (or as a consection of or as a consection or a consection of or a consection of or a c	ancy tal death 31 death 51 certified by the sulting in the tall the sulting in the s	DEctopic pregnancy Other (specify)  underlying cause give bo Cylor  bo Cylor  28c. Injur  Wor  M 1    treet, factory, office th occurred at the timestigation, in my o	26. Place 26. Place 26. Yes 27. A Nu yes 29. A Nu yes 20.	I. e of Death ursing Hom 2   No	23e. Did  1  24a. Wa auto performance of the control of the contro	tobacco us  Yes 2  s an ppsy ormed? 2  No one) idence 6 how injury  (Street and wm, State) e cause(s); d date and	Month  se contribu  No 3  24b. Wer prior deal 1   Other ( occurred	f delivery Da  te to the c Probable e autopsy r to completh? Yes 2[ Specify)  or Rural Red due to the	y Yea  ause of dea  y 4 Unk  findings ava  etion of caus  No
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edical Certification; To Be Completed by Physician/Medical Examiner	25. W 9x 1[ 27. Ma 1 21 29a. (	MALE: Was decedent in the past 12	red to medical No  Pending Could retermine title of certifier	C	o (or as a consecution of or as a consecution of pregration of pregration of pregration of the pregrat	pauence of):  nancy laideath 3i death 5i  sulting in the in  Liveur  ER/Outpatie  28b. Time of Injury  home, farm, st  nowledge, deal	Dectopic pregnancy Other (specify)  underlying cause give by Cylin Jee  ant 3 DOA  of 28c. Injur Wor M 1 Dector  treet, factory, office  th occurred at the time the stime of the second	26. Place 26. Place 27. Al Nu y at k? Yes 2   me, date ar pinion, des	e of Death ursing Hom 2 No 2 and place, a ath occurre	23e. Did  1	tobacco us  Yes 2  s an ppsy ormed? 2  No ormed? (Street and own, State) a cause(s); , date and  29d. Date	Month  se contribu  No 3  24b. Werprior deal 1  Other ( occurred  Number of	f delivery Da  the to the complete autopsy r to completh? Yes 2  Specify)  or Rural Reduction the due to the	y Year  y 4 Unk  findings ava  etion of caus  No  No  oute Numbe.

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ORIGINAL

			-	State of Marylan	d / Depa	artment of H	lealth and	Mental Hv	aiene	2001	
		•	For State Registrar	o tallo o man y tal		rtificate of			Reg. No.	2004	42059
	9.0		Decedent's Name (First, Middle, Last	st)				2. Date of De	ath		3. Time of Death
	Physicia /Medic		Mary Kwamboka Ny	amweya				Month Decembe	r 11	, 2004	6:35 P M
7	Examin		4a Facility Name. (If not institution, give Transitional Care	street and number)	r at	4b. City, Town, o	or Location of De	ath	4c.	County of Deat	h
			Holy Cross Hospi			Silver	Spring		M	ontgome	
	Funeral		Social Security Number     6. S	ex 7. Age (In yrs.		If Under 1 Year Months Days	1f Under 24 H	n.   (Month, Da	th ly, Year)	9. Birtl	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	0	J 115.			March 1	7, 19	41   Ke	nya
	and and	ŀ	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation			-		10d. Inside City Limits
	Mary -f sho	ō	Maryland Monto	gomery Si	lver S	nrina					1 ☐ Yes 21 No
	28a	Directo	10e. Street and Number	JOINELY 51	IVCI D	10f. Zip Code			10g. Citiz	zen of What Co	untry?
	3e ol		2326 Georgian W	oods Place		20902			v	enva	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.			(Specify Yes or No erto Rican, etc.)		14. Race - Ame Black, White	
٥	after or Ite		1 🛣 Never Married 2 ☐ Married	1 ☐ Yes 2 🖾 No		1 □ Yes 2K© No		orto rusari, etc.,		Specify: Bla	
21215-0036	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f show clical Evanturer must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							
ភ្ន	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w	vorking		nd of Business/	•
7	within	d L	Elementary/Secondary (0-12)	College (1-4or 5+) 4		al Lab Te	•	<b>.</b>		th Mair Organiz	ntenance ation
	be filed within 72 ho tal Hygiene. Id other then "natur event, If a Medical	ပ္ပို	17. Father's Name (First, Middle, Last)		Inedica	ar nan re	1	ame (First, Middle			d c I o i i
Maryland	ould be Mental arked o	To Be	Elizaphan Maobe	Nyamweya			Trupher	na Getega	Mic	hieka	
<u></u>	should nd Men marke umatic	F	19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street		Rural Route Numb			Tip Code)
	es 1 and 2 should be of Health and Mental item 27 is marked or rother treumatic ever	į	Demitria N. Nyamw	eva/Daughter	2326	Georgia	Woods I	Place, Si	lver	Spring	, MD 20902
ē,	s 1 a of Hei		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of matory or other pla	(ce) Dogs	Date 2.2	20c. Lo	cation - City or	Town, State
Ë	Pages nent of ant: If it		1 🖾 Burial 2 □ Cremation 3 🛣  `4 □ Donation 5 □ Other (Specify	Hemovel from State		al Land	pece	ember 23, 2004	Kisi	i. Kenv	a, Africa
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Funeral Service Licer	DSBB O	-22 Fr	2. Name, and Addre	ess of Facility	Funeral			<u>.,</u>
m	P P E E B		* Unchen	fole				d, W, Si			, MD 20901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the deal	th. Do not ent	er the mode of dyi	ng, such as card	iac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Gastric Car	cer						Onset and Death
*	/Medical		resulting in death)	Due to (or as a consec							
	Examiner		Sequentially list conditions, if any, leading to immediate	b. Pancytopeni							
	pe tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):						
_	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):						
760	be executed sician and burial-transit	calE	· ·								
687	e Se	=		0.							
Box	death certifical e attending phy od for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		75			2	23d. Date of deli	very
	death e atte	icia	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 Feta		<pre>JEctopic pregnanc</pre> <pre>J Other (specify) _</pre>	:у			Month	Day Year
<u>Р</u>	tt the by th tache	hys	9 Unknown	9□ Unknown							
	The law requires that the de ste has been signed by the bage 2 should be detached	by F	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.				the cause of death?
Records,	equire en si ould l							- 10	Yes 2L	JNo 3□Pr	obably 4 Munknown
ပို	2 2	Completed						24a. Was	psy	prior to d	topsy findings available completion of cause of
	The ate h	Con						1 Yes	2.No	death?	2□ No
/ita	Physicien: The this certificate har al director, page	Be (	25. Was case referred to medical examiner?	I I a - site l				eath (Check only	one)		
of	Physi this o	<sup>2</sup>	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	IL 3 DOA		Home 5 ☐ Resi			cify)
Division of Vital	ding P	ion	27, Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk? ]Yes 2 □ No	28d. Describe	now injury	Occurred	
Sic	l or Attending Phater death. Director: After the	licat	2 Accident investigatio 3 Suicide 6 Could not b	ORO Place of Injury - At h	ome, farm, st			28f. Location (	Street and	d Number or Ru	ral Route Number,
<u> </u>	after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State,	)	
	To the Hospitel or A within 24 hours after To the Funerel Direction Distributed by the formulated in bits of the formulated of the formula			nysicien: To the best of my kn							
	ne Ho n 24 h ne Fu	edical	(Check only 2 Medical Exer	miner: On the basis of examinand manner stated.	ation and/or in	vestigation, in my	opinion, death oc	curred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. Licen	se number		29d. Date	e signed (Month	n, Day, Year)
	10		land		CANNI	E D	60619		12	2/04	
	(0		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)			-	7-	
			Connie Le, M.D					ing, MD	2091	)	
••	Sta Registi		31. Date filed (Month, Day, Year)  DEC 15 2	32. Registrar's Sign	ature 6	Spark	2				

			For Amend Items 2	24 State of Mai					_		_	4	42060	1
						runca	e or L	Cuin	2. Date of Dea				3. Time of Death	-
	Physicia		Decedent's Name (First, Middle, La.     James Clyde Non						Decembe	Day			9:23 A. M	
	/Medic Examin		4a. Fecility Name (If not institution, give	e street and number)		4b. City	, Town, or	Location of Dea	th	4c.	County of D	eath		
	CAUTITI	•	3357 National Pil	<e< td=""><td></td><td>Har</td><td>cock</td><td></td><td></td><td>Wa</td><td>shing</td><td>ton</td><td>1</td><td></td></e<>		Har	cock			Wa	shing	ton	1	
	Funeral		Social Security Number     6. S		(In yrs. last birthda)	y) If Unde	Days	If Under 24 Hrs Hours Min		h y, Year)		Birthpl	ece (State or Foreign try)	7
	Director		214-10-5572  Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Logation			1 Julie 4,1	کندو.			Od. Inside City Limits	_
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hyglene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, I'm Medical Exercities must be notified at ano.	7											1 ☐ Yes 2√☐ No	
	Ba-f	Director	MD Washingt	ion	Hancocl		- Codo			10a Citi	zen of What	Coup		_
	vith t	급	10e. Street and Number	D.11		101. 21	p Code	`		-		Court	пуг	
	8 23s	123	3357 National		una in N.C. de	1 W D	21750		Considu Van ar Na		JSA 14. Race - A	moric	an Indian	_
	er de	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	Verin U.S.	If Yes, spe	ecify Cubar	n, Mexican, Pue	Specify Yes or No rto Rican, etc.)		Black, V			
36	s aft	by F	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	,	1 🗆 Yes	2 X No	Specify:			Specify:	τ.	hite	
Ş	hour tural	pa	15. Decedent's E		16a. Dec	edent's Usu	ual Occupa	tion		16b. Ki	nd of Busine			_
<u>.</u>	n 72 n na leatic	Completed	(Specify only highest gra	ade completed)	(Giv	o kind of w	ork done d	uring most of we	orking				,	
7	with ene.	E C	Elementary/Secondary (0-12)	College (1-4or 5+	·	L Make	r			Too.	l Manu	ıfac	ture	
9	filed Hygid Sther ent, I		17. Father's Name (First, Middle, Last	)	100	LIGING		18. Mother's Na	me (First, Middle,	_				_
an	d be ental ced c	To Be	Hartford H. Norr	ÍS				Aggie	Whorton					
Maryland 21215-0036	should be and Mental marked o umatic eve	-	19a. Informant's Name/Relationship (		19b. Ma	iling Addres	s (Street a		Bural Route Number	r, City o	r Town, Sta	te, Zip	Code)	_
	and 2 eaith a n 27 is		Gary M. Norris/So	on	2034	41 Kir	nes Cr	est Blv	vd. Hacer	stow	m MD	217	42	
ရ	Hea Hea tem othe		20a. Method of Disposition		20b. Place of Dis	position (Na	me of	- 1	Date		cation - City			
Baltimore,	Pages nent of int: if its ury or o	200	1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)  Cemetery, crematory or other place) Piney Plains Cem. 12/21/04  Little O									1ea	ns MD	
₫.	it. P	4	21. Sign ture of Funeral Service Land 22. Name and Address of Facility 141 West											
Ba	permit. Page Department Important: If any njury o			5 ( ) 6					P.A. H					
	70		23a. Part1. Enter the disease, or com-	plications that caused t	he death. Do not e						ren, rid		Approximate	_
	5 0		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	A.L.	7							Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Coronar	y Arten	1 112	eage					-		_
87	Examiner			Due to (or as a	consequence of):									
~=		E.	Sequentially list conditions, if any, leading to immediate	b. Oue to (or as a	contraquence of):							_		
	Insit	m L	Cause (Disease or injury											
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):									_
760,	te be executed ysician and te burial-transit	cail		d										
687	Attending Physician: The law requires that the death certificate r death. sctor: Atter this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the			. u.										
Box 68	renti nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						:	23d. Date of	delive	ry	
ă	death atte	clai	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		B⊟Ectopic p  Other (s					Month		Day Year	
P. 0.	the c y the achec	Jysi	9 Unknown	9□ Unknown										
٣.	s that ned b s deta	by Physiclan/Medl	Part II. Dther significant conditions	contributing to death but	t not resulting in the	underlying	cause give	n in Part I.	23e. Did to	obacco L	se contribut	e to th	e cause of death?	
g	w requires that s been signed I s should be det								1 🗆 🗅	/es 2	]No 3[	] Proba	abiy 4 Donknown	
00	w rec	lete							24a. Was		24b. Wer	e autop	osy findings available	
æ	he la e has age 2	Completed								rmed?	deat	h?	npletion of cause of 2 No	
B	ficat or, pa	C	25. Was case referred to medical					26 Place of De	1 ☐ Yes eath (Check only o		10	162	2L NO	_
5	sicia s cart lirect	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Outpat	ient 3 D	Othe Othe	er.	Home 5X Resid		6 □Other (:	Specify	•)	
ō	ar this		27. Manner of Death	28a. Date of Injury	28b. Time	of	28c. Injury Work		28d. Describe			, , ,	/	_
o	th.: Afte	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	м		res 2 No						
Division of Vital Records,	Atter r dea nctor	ifica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injur	ry - At home, farm, (Specify)	street, facto	ry, office		28f. Location (S City or Tov	Street an	d Number o	r Rura	Route Number,	
á	after I Dira	Certification:	4 Homicide	building, etc.	(Specify)				City of 100	WI, State	,		•	
	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e	examination and/or									
	To the within 2. To the complet	Med	29b. Signature and title of certifier	and manner stat	eu.	26	9c. License	number		29d. Dat	e signed (M	lonth. L	Day, Year)	-
	7 V	Whathe Halm MD D56048 December 21, 2004												
,	0													
	V	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Muthew Hahn, 130 West High Street, Hancock, Mary land 21750												
	17.3		31 Date filed (Month, Day, Year)	170 W037 H	r's Signature	1 1700	coch	1 may a	W. K. 12	V				-
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature  JAN 0 5 2005											

ORIGINAL

	•		1- State of Maryland / Dep	artment of Health and Nartificate of Death		2004	42061			
*8	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day O'Year	3. Time of Death			
	/Media	al		AUMANN	December					
	Examir		4a. Facility Name (If not institution, give street and number)  8341 Flm Road	4b. City, Town, or Location of Death Millersville		Anne Aru				
	Funeral Director		5. Social Security Number 6. Sex 1 1	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y 2/11/1	9. Bin 968 Ma	thplace (State or Foreign buntry)			
	and wo		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits			
	death with the Maryland ms 23a or 28a-f show rmat ke notlified at	tor	MD. Anne Arundel	Millersvil	le		1 ☐ Yes 2 XNo			
	or 28s	Oirec	10e. Street and Number	10f. Zip Code	-	g. Citizen of What Co				
	ath w	ral	8341 Elm Road	21108		nited S				
36	iges 1 and 2 should be filed within 72 hours after death with the Maryian to f Health and Mental Hygiene. If item 27 is marked other than "natural", or litems 23a or 28a-f show or other traumatic event, If a Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No lf Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
2-0	72 hou	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16	b. Kind of Business	Industry			
121	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Donl	ri m ot			
d 2	filed v Hygie Sthar t		12 0 Depa	artment Supervi	e (First, Middle, Ma	Banl	KING			
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ite Me	To Be	Monte LeRoy Blackwell	Janet	Mari	e Stur	np			
lary	2 short			ing Address (Street and Number or Run						
e,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra once.		Leeann Phillips/Sister 128  20a. Method of Disposition 20b. Place of Disp	Mussetta St.		r, Pa. I				
Baltimore,	ages ant of h it: if ite y or of		1 ☐ Burial 2 Cremation 3 ☐ Removal from State	amatory or other place)						
altin	permit. Pa Departmen Important: any injury once.	Ì				ampstead	Maryland			
ä	Depa Impo any ir		Mackelen Kurg	E.G. Kurtz &	Son Fun	eral Hor				
	Physician Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each libb.  Immediate Cause (Final disease or condition a. Gunshot ws.	or respiratory arrest	l,	Approximate Interval Between Onset and Death				
	/Medical Examiner		Due to (or as a consequence of):							
7	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury)							
V CA	ate be executed hysician and the burial-transit	Examin	that initiated events c.  resulting in death) Last Due to (or as a consequence of):							
8760,	sate be ex physician the buria	dlcal	d							
89 x	ertifica ling ph	0 1	IF FEMALE:	-						
P.O. Box	The law requires that the death certificate tte has been signed by the attending physioage 2 should be detached for use as the face.	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year			
چ. ح	w requires that the de been signed by the should be detached	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
ord	equire sen sig	ted t			1 ☐ Yes	2 No 3 □ Pr	obably 4 Unknown			
Records,	e law r has be ye 2 sh	Completed			24a. Was an autopsy performe	prior to o	topsy findings available completion of cause of			
			25. Was case referred to medical	OS Place of Part	1 Yes 2	No 1 Yes	2□ No			
Ž	ys di S	To Be	examiner?  1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other	n <i>(Check only one)</i> me 5□ Residenc	ce 6 X Other (Spec	cify)At scene			
Division of	ng Ph (fter th Ineral		27. Manner of Death 1 □ Natural 5 □ Pending   28a. Date of Injury (Month, Day Year)   28b. Time Injury	of 28c. Injury at Work?	28d. Describe how	injury occurred				
Sio	ttandi death. tor; A the fu	icatl	2 Accident investigation 12-21-04 teind 10	46 M 1 □ Yes 2 0 No		was sho	·			
Div	al or Al	Certification;	28e. Place of Injury - At home, farm, s building, etc. (Specify)	Ď.	City or Town, S Millers ville	et and Number or Ru State) 8341 E	iral Houte Number,			
	To the Hospital or Attanding Physician: within 24 hours after deals.  To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director.	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal on the basis of examination and/or i and manner stated.	th occurred at the time, date and place,	and due to the caus	se(s) and manner as	stated. to the cause(s)			
	To t withi To tl	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		Date signed (Month Cember 22				
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 111 Penn Street, I	Baltimore	Marylan	1 21201			
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		MICTINUTE	, raryralk	1 21201			
	Registr	ar	JAN 0 4 2005 Been &	e filed (Month, Day, Year)  32. Begistrar's Signature						

Deborah E. Nixon 04-8201 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department	artment of Health and rtificate of Death		iene2 0 0 L	42062
	Physici /Medic		Decedent's Name (First, Middle, Last)     DEBORAH ELIZABETH NIXON		2. Date of Dear Month Decembe	Day Year	3. Time of Death  1:37 P M
	Examin Funeral Director	er	4a. Fecility Name (If not institution, give street and number)  Route 51 south of Couriers Run Road  5. Social Security Number 6. Sex 1 M M Tr. Age (In yrs. last birthday)  18-64-8421 Tr. Age (In yrs. last birthday)	4b. City, Town, or Location of Dea Cumber land  If Under 1 Year If Under 24 Hrs  Months Days Hours Min	8. Date of Birth	4c. County of Death Allegany 9. Birth 7987952 Mar	n nplace (State or Foreign inity) 191and
	ט	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Low  WV Hampshire Green Spi				10d. Inside City Limits 1 Tyes 3 No
	th with the 1 23a or 28a-	al Director	10e. Street and Number PO BOX 36	10f. Zip Code 26722	1	0g. Citizen of What Co	untry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is Modical Examination in Italian along.	by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ <b>X</b> o Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
21215-0036	l within 72 ho iene. r than "natur the Wedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Dece (Give life.)  College (1-4or 5+)  Homer	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) naker	orking	16b. Kind of Business/I	industry
Maryland 2	uld be filed Mental Hyg Irked other Itic event,	To Be C	17. Father's Name (First, Middle, Last)  ROBERT S. NIXON		me (First, Middle, I		SON
	and 2 sho ealth and ? m 27 ia ma her trauma		DOROTHY R. SAVILLE RT. 1	ng Address (Street and Number or R. L., Box 178A, Paw	Paw, WV_	25434	
altimore,	hit. Pages 1 artment of H ortant: If ite injury or ott		20a. Method of Disposition  1 Burial 2 Commation 3 Removal from State  4 Donation 5 Outher (Specify)  21. Sign livre of Funeral Service Licensee	21/04	20c. Location - City or Cresaptown Tnick Funer	, MD	
Ba	Depart Impo		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	BO E. Main S	t., Romne	ey, WV 267	57 Approximate
68760,	/Medical Examiner be executed by physician and street transit	edical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):	njuries			Interval Between Onset and Death
P.O. Box 6	death certi e attending ed for use a	Physiclan/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tol	bacco use contribute to es 2 ⊠No 3 ☐ Pro	the cause of death?
of Vital Records,	The ate h page	Completed			24a. Was a autops perform	sy prior to d	topsy findings available completion of cause of
Z.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 XXes 2 □ No  Hospital: 1 □ Inpatient 2 □ ER/Outpatien	A.1	ath (Check only on		240 E7 1 - E 10 50 50 50 70 70
ion of	Attending Physic death. sector: After this by the funeral di	ertification: T	27. Manner of Death 1 □ Naturat 5 □ Pending 2 ★ Accident investigation   28a. Date of Injury (Month, Day Year)   28b. Time of Injury (Month, Day Year)   1 . 21		28d. Describe ho	ow injury occurred.	CAT accident
Division	in the or	0	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	+	Couriers R	treet and Number or Ru n, State) Result S in Ril - Cumil	iland, Mi)
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, deat (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, deat (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, deat (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge, deat (Check only one)	vestigation, in my opinion, death occ	urred at the time, d	ate and place, and due	to the cause(s)
}	To wit To		29b. Signature and title of certifier  Zalmullah H	O.C.M.E.		9d. Date signed (Month December 21	
	١		30. Name and address of person who completed cause of death (Item 23a) (Type, ZABIULLAH AL(		Baltimor	e, Maryland	d 21201
^	Sta Registi		31. Date filed (Month, Day, Year)  JAN 0 4 2005  JAN 0 4 2005	W			

				artment of Health and Menta	al Hygiene	42063						
			Decedent's Name (First, Middle, Last)	2. Da	te of Death	3. Time of Death						
	Physici /Medic		ROY B. O' NEAL, SR.		cember 20 2	004 2025₽M						
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	eath						
			Sun Bridge Care & Rehab.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Elkton If Under 1 Year   If Under 24 Hrs.   8. Da	Cecil te of Birth 9. E	234						
	Funeral Director		222-05-4306 X2 M 2 F 85 Yrs.	Months Days Hours Min. (Min. 2-	onth, Day, Year)	Birthplace (State or Foreign Country) aryland						
	Q.		Usual Residence of Decedent		11							
	show	'n	10a. State 10b. County 10c. City, Town or Lo Delaware New Castle Middlet			10d. Inside City Limits 1 ☐ Yes 2 ∑tNo						
	the M	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What							
	Mith Be or	Ē	475 Boyds Corner Rd.	19709	USA	Cooming:						
	death ms 2;	Funerai		Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,	es or No- 14. Race - Ar	nerican Indian,						
ထ္	after or ite	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2X No Specify:		white						
Ö	hours tural',	d by	3 Wildowed 4 Divorced Year or Dates:									
7	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madical Exametra must be mattled at	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Busines	ss/industry						
212	d with giene.	om	Elementary/Secondary (0·12) College (1-4or 5+) Auto	Assembly Worker	Auto Ma	nufacturing						
<u>p</u>	al Hyg	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)							
<u>yاa</u>	ould b Ment Marked	10	John O'Neal		<u>ill</u>							
Maryland 21215-0036	12 sh h and 7 is m treum			ing Address (Street and Number or Rural Route  O Yellowstone Driv	-							
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, ite Medical Examinar must be natified at		20a Method of Disposition 20b. Place of Dispo	osition (Name of Date	20c. Location - City							
Baltimore,	0 0 = F			matory or other place) d Cemetery 12-23-(	04 Townsend	l. DE						
≣	permit. Pag Department Importent: any injury conce.			2. Name and Address of Facility DANIEI								
Ö	P P P P P P P P P P P P P P P P P P P	D 1		212 N. Broad St., N								
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between						
E	Physician		Immediate Cause (Final disease or condition a.	otie Heart Discase		Onset and Death Unbncm						
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	11 to Park	my Disease							
		-e	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	skucine ramous	my viscose	uninus						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	gran (		Unknown						
Ó	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):	1								
8760,	cate be executed physician and the burial-transit	dicai	d									
9	ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		and During	1-15						
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (s <i>pecify</i> )	23d. Date of o	Day Year						
0	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown									
ري ص	res that igned b	y PI	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23	Be. Did tobacco use contribute	to the cause of death?						
ğ	w require been sig should b				1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Denknown						
Vital Records,	law ras be	Completed		24	autopsy prior t	autopsy findings available o completion of cause of						
<u>~</u>		Con		1[	performed? death Yes 2 ☑ No 1 ☐ Y	? es 2 \( \text{No} \)						
Ĕ	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Chec								
	Phys	. To	27. Manner of Death 28a. Date of Injury 28b. Time of	nt 3 DOA 402 Nursing Home 5	Residence 6 Other (Specified how injury occurred	oecify)						
on	Attending is death. ector: After by the funer	atior	1 ☑Natural 5 ☐ Pending (Month, Ďaý Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No								
Division of	er deg recto	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)		cation (Street and Number or by or Town, State)	Rural Route Number,						
◚	ital or A											
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier  1 ☐ Certifying Physician: To the best of my knowledge, deal (Check only one)  1 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and dunivestigation, in my opinion, death occurred at the	e to the cause(s) and manner ne time, date and place, and d	as stated. ue to the cause(s)						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	nth, Day, Year)						
	⊢ s ⊢ ō		Aachder-S-MIS	D0023322	12.21	. 2004						
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Suite 3B, Eleter								
	Sta	to	31. Date filed (Month, Day, Year)  32. Registrar's Signature	y our os, c rem	1. (12)							
	Registr		ate filed (Manth, Day, Year)  DEC 2 2 2004  32. Registrar's Signature									

		4	1 - For State Registrar	State of M	arylan		artment tificate					Reg. No.		4206	; 4
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Myrtleen Olive	r						D	2. Date of De Month Decembe	r 15	, 20°04	3. Time of Deal	
	Examin	_	4a. Facility Name (If not institution, Fairland Nursin	g and Rehal	. Cen		Silve	er Sp	Location of	s		Mon	County of Dea	y 	
	Funeral Director		074-64-4860	6. Sex 7. A 1	90	Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Bird (Month, Da LUGUS C	y, Year)	9. Bir Cc 914 G1	thplace (State or For buntry) 1yana, SA	aign
	Maryland -f show lied at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Montgo	mery		y, Town or Lo			-					10d. Inside City Lir 1 X Yes 2 ☐	
	or 28e	Director	10e. Street and Number				10f. Zip						en of What Co	ountry?	
036	2 should be filed within 72 hours after death with the Maryland and Mentle Hygiene. Is marked other than "natural", or Itams 23s or 28s-f show eumatic event, the Medical Examinat must be notified at	by Funerai	3609 Valiant Wa  11. Marital Status  1 Never Married 2 Marrie  3 XWidowed 4 Divorced	12. Was Deceder Armed Forces	s? <b>X</b> No			ify Cubai	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No ican, etc.)		A. Race - Ame Black, Whit Specify: B1a	e, etc.	
Maryland 21215-0036	thin 72 ho re. ren "natur redical i	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		r 5+)	16a. Dece (Give life.	kind of wor DO NOT us	k done d e retired,	luring most )	of working	g	16b. Kii	nd of Business		
מי	filed wi Hygien Sther th		12th 17. Father's Name (First, Middle, L	.ast)			Т	each		r's Name	(First, Middle,		Lvate Sumame)		
ylan	Mental Mental arked c	To Be	Winston Holder								Griff				
Mar	5 to 5		19a. Informant's Name/Relationsh Cecelia Wiltshi		r								Town, State, .		
ore,	es 1 an of Heal if item 3 r other		20a. Method of Disposition 1 ™ Burial 2 □ Cremation	3 □Removal from Sta	20b. P	Place of Disponentery, crea				Da			cation - City or		
Baltimore,	permit. Pages Department of It importent: If ite any injury or of		*4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral-Service)	ecify)		22	2. Name and	d Addres	s of Facility	<sup>y</sup> Johns	son & .	Jenk	lphi, M lns Fun DC 20	eral Home	
ľ			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each	ed the deatl line.									Approximate Interval Between Onset and Death	1
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alzheir Due to (or a	ner's		:ia							2yrs	
760,	certificate be executed by ding physician and burial-transit buria	ıi Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Literate or injury that initiated events resulting in death) Last	c.											
O. Box 687	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	d.  23c. If yes, outcom 1  Live birth 4  Pregnant	2 Feta at time of d	Ideath 3[	Ectopic pro					2	3d. Date of de Month	ivery Day Year	
ds, P.	uires that I signed by lid be deta	by	Part II. Other significant condition Anemia	ns contributing to death	but not res	ulting in the u	nderlying ca	ause give	en in Part I.			obacco u Yes 2[		o the cause of death	
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed									24a. Was autop perfo		prior to death?	utopsy findings availa completion of cause 2 No	able of
Vital	Physician: Tr this certificate ral director, pay	Be	25. Was case referred to medical examiner?	Hospital:				A Othe	20		(Check only o	one)			-
Division of	ding Phys h. After this tuneral dii	tion; To	1 ☐ Yes 2√☐ No  27. Manner of Death  17☐ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date of Ir		28b. Time o Injury		Bc. Injury Work	4 ÇZ IVU	28	e 5 Resi		Other (Spe	cify)	
Divisi	i i i i i	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 289. Place of	Injury - At he etc. (Specif		reet, factory	, office		2	Bf. Location ( City or To			ural Route Number,	
	Hospitei 24 hours a Funereill etely tilled	edical (		g Physician: To the be Examiner: On the basis and manner	of examina										
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier				29c	. License	number			29d. Dat	e signed (Mont	h, Day, Year)	
			30. Name and address of person v	who completed cause of	f death (Item	n 23a) (Type		D286	56			Dece	mber 16	, 2004	
			Ravi Passi, MD	8609 2nd A	ve. S	uite 4		ilve	r Spi	rings	, MD 2	0910			
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 1 7 20		strar's Signa	ture	the)								

Registrar
DHMH 17 Rev 1/2001

State

Aditya Chopra, M.D.

DEC 2 1 2004

31. Date filed (Month, Day, Year)

Suite 231

Annapolis, MD. 21401

600 Ridgely Ave.

32 Registrar's Signature

		State of Maryland / Department of Health and Mental Hygiene Amend #26 per PHYS Certificate of Death  State of Maryland / Department of Health and Mental Hygiene Amend #26 per PHYS Certificate of Death  Reg. No. 004
Physi /Med	lical	1. Decedent's Name (First, Middle, East) 22/04 ELM  Prances Perrin  4a. Facility Name (If not institution, give street and number)  2. Date of Death Month Day Year  December 12, 2004 3:46 a M  4b. City, Town, or Location of Death  4c. County of Death
Funera Directo	ıl	Prince Georges Community Hospital Cheverly  5. Social Security Number 6. Sex 1 I M 25 F 84 Yrs.  Recommendation, give steet and mander)  4c. County or beam  4c. County  4c. C
he Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  DC Washington 10d. Inside City Limits
altimore, Maryland 21215-0036  Int. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ahrment of Heath and Mental hygiene.  Orient: If item 27 is marked other then "neturel; or Items 23e or 28a-1 show injury or other treumetic event: I'm Medical Evan in art must be retilized.	ed by Funeral Director	10e. Street and Number  2018 Evarts Street NE  20018  11. Marital Status  1
aryland 21215-0036 should be filed within 72 hours aft and Mental Hygiene. I marked other then "neturel", or imetic event. I'm Medical Eversi	To Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)
ire, Maryland s 1 and 2 should be file f Health and Mental Hy tiem 27 is marked oth other treumetic event		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Patricia Beynum/Niece  2018 Evarts St. NE Washington, DC 20018  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore, cernit. Pages 1 are cernit. Pages 1 are cernit. If item eny injury or othe	KIRK	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Johnson & Jenkins Funeral Home  716 Kennedy St. NW Washington, DC 20011
Physiciar /Medica Examine		23a. Part1. Enter the disease, or complications of at caused the duth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the causes on each line.  Immediate Cause (Final disease or condition resulting in death)  a
Records, P.O. Box 68760,  The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	ledical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.
.O. Box 61 the death certific y the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1
Records, P.O. I he law requires that the de e has been signed by the age 2 should be detached it.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
	Be Completed	24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  26. Place of Death / Check only one)
on of ding Phys I. After this funeral di	Certification: To	1   Yes 2   No
Division  To the Hospitel or Attention Within 24 hours after deatl To the Funerel Director: completely filled in by the		4 Homicide determined determined determined determined determined 259. Place of Injury - At home, farm, street, factory, office 259. City or Town, State)  291. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the H within 24 To the Fo complete	Medical	(Check only one)  2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29b. Signature and title of certifier  29c. License number  29d. Date, signed (Month, Day, Year)  4116 10 4  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S Regis	tate trar	Dr. Richard Rees 6500 Riggs Road Hyattsville, MD  31. Date filed (Month, Day, Year)  DEC 2 2 2004  DEC 2 2 2004

			1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of H	ealth and M Death		ene 200	4 4206		
I	Physici	an	Decedent's Name (First, Middle, Last)		-			2. Date of Death Month	Day Year	3. Time of Death		
);	/Medic		CLARENCE DOUGLAS  4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death	Decembe	r 15, 200			
	Exami	lei :	Lorian Franford Re			Baltimon				7		
	Funeral		Social Security Number     Sex     1 X	7. Age (In yrs. )		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign		
G	Director		Usual Residence of Decedent	89	Yrs.			Feb. 12,	1915 Vi	rginia		
	nyland how		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
	h the Marylan	Funeral Director	Maryland Prince Ge	eorge's Col	lege P					1 N Yes 2 No		
	with the	Dire	10e. Street and Number			10f. Zip Code			g. Citizen of What C	ountry?		
	death	era	5812 Bryn Mawr Roa	2. Was Decedent Ever in U.	S. 13. V	20740 Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp		14. Race - Am	erican Indian,		
õ	thin 72 hours after death with the Maryland e. Marical Ezant, or items 23a or 28a-f show Marical Ezant, sermunt be natilised at		1 ☐ Never Married 2 💢 Married	If Yes, Give	42-	Yes, specify Cubai		Rican, etc.)	Black, Wh	ite, etc.		
5-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates: 194	5	ent's Usual Occupa				White		
<u>.</u>	nin 72 in "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) Colfege (1-4or 5+)	(Give	kind of work done d OO NOT use retired,	luring most of worl	king	3b. Kind of Busines:	windustry		
7	filed within Hygiene.	Com	12	College (1-40f 5+)	Resta	urant Mar	nager		Restauran	t		
D D	d ta b	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M.	aiden Sumame)			
Maryland	should and Men marks umaric	2	Cleve Patsel  19a. Informant's Name/Relationship (Type	e Print)	19h Mailin	Address (Street a	Lucy Th		City or Town, State, Zip Code)			
_	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Nellie Patsel - Spe	•	1					land 20740		
altimore,	of He		20a. Method of Disposition  1 Derivation 2 Cremation 3 Re	20b. P	lace of Disposemetery, crem	sition (Name of atory or other place	g)		C. Location - City o			
Ĕ	Pages ment of ant: If it ury or o		1 □ Burial 2 ☑ Cremation 3 □ He 1 □ Burial 2 ☑ Cremation 3 □ He 1 □ Burial 2 ☑ Cremation 3 □ He	ILLIONAL HORR STATE	coplita	n Cremato	ry   12/2	0/2004 A	lexandria	, Virginia		
ala	Definit. Page Department of Important: If eny injury of once.		21. Signature of Funeral Service License	e ,					neral Hom			
	2220		23a. Phys. Enter the disease, or complic	ation that caused the death					tsville,	MD 20781 Approximate		
	Physician		shack, or heart failure. List only one Immed to Cause (Final	a cause on each line.					• 1	Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	y D ( C . ►	ntery	n threl	100		30'		
	Examiner	_	Sequentially list conditions, b.	Ononay Due to for as a consequent	y a	ntery	2184	986				
	tusit	Examiner	Sequentially list conditions, and because. Enter Underlying Cause (Disease or injury	Oue to tor as a consequ	sence cry:							
ĵ	be executed ician and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):							
2/60	ate be	Ical	d.									
õ ×	w requires that the death certificate been signed by the attending phys should be detached for use as the	/Med	IF FEMALE:	c. If yes, outcome of pregna	DOV							
X D	death of e atten-	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal  4 Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
л Э	t the d by the	hysi	9 Unknown	9□ Unknown								
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions cont		-	derlying cause give	n in Part I.		. /	o the cause of death?		
coras,	requir	eted	Respire ton	acont beil	urc			1 Yes	2⊠No 3□P	robably 4 Unknown		
٩N	e S. CA	Completed	Respirator	7 Fullur	<i>e</i>			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of		
VII	in: Th	e Co	25. Was case referred to medical				26 Pines of Door			3 2 □ No		
<u> </u>	ysicie lis cert direct	To B	examiner?	espital:	ER/Outpatient	3□ DOA Othe			ce 6 □Other (Spe	cify)		
lo u	Ing Pt Viter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred			
DIVISION	ttendi death.	icatl	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ma farm atra		′es 2 □No	79f Location /Ctro	et and Number or R			
2	after after Direct d in by	Certification:	4 Homicide determined	building, etc. (Specify	<i>')</i>	et, factory, office		City or Town,		urai Houte Number,		
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) (Check only one)	cian: To the best of my knower: On the basis of examinat and manner stated.	wledge, death lion and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the cau red at the time, date	se(s) and manner a and place, and du	s stated.  To the cause(s)		
	To th within To th Compl	Me	29b. Signature and title of certifier	1/		29c. License		290	. Date signed (Mon.	h, Day, Year)		
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(	114		30. Name and address of person who com	. 1	23a) (Type, F	Print)	١,,, ۵,,	0 ~ 12	ltimore	21201		
	Sta	te	31. Date filed (Month, Day, Year)	1 toward 3 Registrar's Signal	ture 0 A l	N. EUI	rw -4	07 176	x P more	, (40		
187	Registr		<b>n</b> FC 2 2 2004	L. L.	-							

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 200142068 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 20, Zawdie A. Proctor 2004 1:33A December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George Largo Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 10X M 2 □ F 33 Yrs. Director 215-11-6946 22, 1971 Washington, DC. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at Clinton Prince George 1 Yes 2 No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Departit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: If flam 27 is marked other than "nature" any injury or other traumatic average. 20735 United States 7706 Canberra Place Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 4 Elementary/Secondary (0-12) N/A Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donna Pierce Michael E. Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20735 7706 Canberra Place; Clinton, MD. Donna Richardson/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery Dec. 23, 2004 Clinton, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 23a. Part1. Enter the dispass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RATORY **Physician** disease or condition resulting in death) /Medical SCLE ROSIS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 1 Tyes 2 🔀 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 🛮 Natural death. 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours a To tha Funaral L 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 2 3883 06

Registrar

DEC 2 2 2004

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Were it sperte

Venkat Ramanan, M.D. 50 Post Office Rd; Suite 304; Waldorf, MD.

20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 [s 42069 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Voor Physician 5:10 P M Dorothy P. Pattison December 19 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11390 Frederick Road Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 218 74 6105 92 Director Dec 13, 1912 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Exercise must be rediffed at 1 ☐ Yes 2 ☑ No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11390 Frederick Road 21042 United States Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiene. Int: if item 27 is marked other than "naturel", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert I. Martin Lula M. Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11394 Frederick Road Ellicott City, MD 21042 Carolyn Deverin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Importent: if its any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Christ Episcopal Cem. 12-23-2004 Columbia, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rupruse Immediate Cause (Final disease or condition Thorseic Aosta **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2K No 1 Tyes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Implicate Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) lecemen 20, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (4, a2 Play Colensia, no 21004 11055 Little Parent JERRY LEVISE, NO 32. Pojistrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

			1 - For Registrar	State of Maryland / [	Departme Certifica	ent of H	lealth a	ınd Me		iene 00 4	42070		
			Decedent's Name (First, Middle, Last,	)				2	. Date of Death	า	3. Time of Death		
	Physicia /Medic		Robert Smallwood	Poole				D	Month ecember	Day Yea	а а м		
<b>)</b>	Examin		4a. Facility Name (If not institution, give	street and number)	4b. C	ty, Town, o	r Location of			4c. County of De	*		
			6108 Western Aver		c	hevy	Chase			Montgor	nery		
	Funeral		5. Social Security Number 6. Sec.	MM 2□F	Yrs. If Un Month	der 1 Year	Hours	Min.	. Date of Birth (Month, Day,		irthplace (State or Foreign Country)		
	Director		579-30-0249 Usual Residence of Decedent	76	115.		1	F	eb. 18,	1928 Was	shington, DC		
	/łand		10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limits		
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	th wil		6108 Western Av	<i>r</i> enue		20815				USA			
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was De If Yes, s	cedent of H pecify Cuba	lispanic Orig an, Mexican,	gin? (Specif , Puerto Ric	y Yes or No- can, etc.)	14. Race - Ar Black, W	nerican Indian, nite, etc.		
36	s afte	by Fu	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give 1965 - 67	1 ☐ Yes	2 🔀 No	Specify:			Specify: Wh			
215-0036	within 72 hours after death with the Maryland ane. Then "naturel", or liems 23e or 28e-f show the Madical Examiner must be notified at	ed b	15. Decedent's Edu	Year or Dates: 1982-96	Decedent's U	sual Occur	ation			l6b. Kind of Busines	ss/Industry		
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g	e filec Il Hyg othe	BeC	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (F	First, Middle, M	faiden Sumame)			
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents: If fem 27 is marked other then "naturel; or liems 23e or 28e-1 show any injury or other treumstic event, tre Madical Examinet must be notified at once.		19a. Informant's Name/Relationship (T)	rpe, Print) 19b	. Mailing Addr	ess (Street	and Number	r or Rural P	Route Number,	City or Town, State	, Zip Code)		
Σ.	and		Kathleen Torney Po				Avenue			se. MD 20	815		
ore	Se di		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ F	cemeter	Disposition (I ry, crematory of	r other plac	:e) De	Date Cembe	er 16,	Oc. Location - City	or Town, State		
Ě	Pag ment tent:		* 4 □ Donation 5 □ Other (Specify)	LIC CI	opolita emator	7	1	2004	1 A		, Virginia		
Baltimore,	ermit.		21. Signature of Funeral Service Liners		Franc	and Addre	ss of Facility	ns Fu	neral	Home Inc			
	0 □ <b>□ □ □</b>			,,,	500 U	niver	sity E	Blvd,	W, Sil	ver Sprin	g, MD 20901		
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	/Medical Examiner		<b>f</b>	Due to (or as a consequence	of):								
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O. B	at the dea by the at tached fo	sici	1 Yes 2 No	4☐ Pregnant at time of death 9☐ Unknown	5 🗌 Other	(specify)				Month	Day Year		
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Records,	w require been si should b	Completed											
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a			OF War and advantage madical						1 ☐ Yes 2	No 1 □ Ye	es 2 No		
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ō	0 # 0 -	Cert	4 Homoles	building, etc. (Specify)					Oity of TOWIT,	Siale)	,		
	To the Hospitel within 24 hours a To the Funerel I completely filled		29a. Certifier 1 X Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination an	dor investigation	ed at the tin	ne, date and	d place, and	d due to the car	use(s) and manner	as stated.		
	To the H within 24 To the F complete	Medical	one)	and manner stated.				5556/160					
	To To Con	2	29b. Signature and title of certifier	he so as A		29c. Licens	e number		29	d. Date signed (Mo	nth, Day, Year)		
	10+1		811110	D25818 December 15, 2004									
(10	5)		30. Name and address of person who con Sean M. Dwyer, M.			70	1025	Ch a	Cha	MD 2003	E		
	Sta	ta	31. Date filed (Month, Day, Year)	32. Registrar's Signature				cnevy	cnase	, MD \\ \O81	<b>5</b>		
	Registr		DEC 16 20	04 Server	5 A	ook.	2d						

Maximiliano Portillo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 08344State of Maryland / Department of Health and Mental Hygiene 1 - State Unpend Item 23a,27,28a-f per me G839 I-25-05 fas

Certificate of Death

Reg. No. 42071 RJ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year December 25, 2004 09:14 P.M Maximiliano Portillo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 8, 19 6. Sex **Funeral** 9. Birthplace (State or Foreign 1<del>X</del>M 2□F Months Days Hours Yrs. 30 1974 El Salvadore Director None Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show offcat Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Virginia | Fair£ax Falls Church 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2959 Patrick Henry Dr. #202 22044 El Salvadore Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify: EI Salvadorian þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed The Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Andres Santos Mercedes 2 Portillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s Health an 2959 Patrick Henry Dr. Falls Church, VA. 22044 Jose L. Portillo Santos (brother) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Its
any injury or ott San Miguel, El Salvadore 1 🔀urial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Ciudad Barrios 21. Signature of Euroral Service Licensee 22. Name and Address of Facility Advent Funeral & Cremation Service MO0982 7211 Lee Highway Falls Church, Virginia 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Alcohol Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) ned by the a o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2□No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Jo Page 12-25-04 Found Found 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: unk After or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ Wo 2 Accident 8:25 the (X) Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Boute Numbers. City or Town, State) 1518 Beaver Higts. in by 4 Homicide Found at home Lane, Capital Heights, Md within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier OCME December 26, 2004

Registrar

State

MANYAMOR

31. Date filed (Month, Day, Year)

Myrie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**DEC 2 9** 2004

A KOREU

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Departr

ment of Health and	Mental Hygien	0	0	L	L	2	0	7	6
icate of Death	Reg. No.								_

GLENN	E. PEAF	RCE	1 - State Registrar	State of Mary	and / Dep	artmen rtificate	t of H	ealth and Death		gien <b>e () ()</b> Reg. No.	L	42072
	Dhuaisi		1. Decedent's Name (First, Middle, Last)						2. Date of De	ath	Year	3. Time of Death
	Physici /Medio		Glenn Edward						DEC.	19, 2004		0330 A M
	Examir	ier	4a. Facility Name (If not institution, give s 21520 YORK ROAD	treet and number)		MARY	LAND	LINE		4c. County o	MODE	
	Funeral Director		210 11 1033	M 2□F 7. Age (In 60	yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da Dec.	DALIJ	9. Birthpla Countr Penr	ce (State or Foreign y) nsylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or L	ocation				<del> </del>	100	d. Inside City Limits
	Mary B-feh	tor	MD Baltimon	ce	Maryla	ınd L	ine					1 ☐ Yes 2X No
	vith the	Dire	10e. Street and Number			10f. Zip				10g. Citizen of W		y?
	eath v	Funeral Director	21520 York Rd	2. Was Decedent Ever	in U.S. 13		211(		Specify Ves or No	U.S.A	- Americai	n Indian
Baltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Informatic if marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once.		1 X Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	i	If Yes, spec		Specify:	Specify Yes or No to Rican, etc.)	Black Specify:	, White, et Whi	c.
5-0	72 hc natur	etec	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usua kind of wor	l Occupa k done d	tion uring most of wo	rking	16b. Kind of Bus		,
121	within lene. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		.ce O				Police		County
200	e filed ai Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Sumame		
<u>8</u>	ould b Menta Marked	To	Herbert Wallac							Brindle		
<u> </u>	d 2 sh thand 7 iem traum		19a. Informant's Name/Relationship (Type Herbert W. Pea	·		-				er, City or Town, S		,
نه	s 1 and f Healitem 2		20a. Method of Disposition	20	b. Place of Dispe	osition /Nan	ne of		Date 23,	Line, i		
0	Page nent o ant: if ary or		1 X Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	vernon Methodi	"Unit Lst Ce	jed mete		04	White	Hall	, MD
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line.							A to	Approximate nterval Between
	Enysician /Medical		Immediate Cause (Final disease or condition resulting in death)	MHEROSU	_	CF.	hadi	WASU	MR 01	JUK32		Onset and Death
	Examiner			Due to (or as a cor	nsequence of):							
12		ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sactionica of):							
Vil	ficate be executed physicien and sthe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	-								
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687	tificate g phys	edicai	d.									
Вох	eath certif attending for use a	M/UE	23b. was decedent pregnant	Bc. If yes, outcome of pro		⊒Ectopic pro	oonanev			23d. Date	-	
	Attending Physician: The law requires that the death certific death, redeath, redeath, experience After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown		Other (sp				Mont	h D	ay Year
0.	that the	Phy	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	ınderlying ca	ause dive	n in Part I.	23e. Did to	obacco use contrib	oute to the	cause of death?
d.	luires than signed		DIABETES	TELLITUS		, ,			1 🗆 1	/es 2 □ No 3	Probab	oly 4 Olynknown
OS	aw requir	plete							24a. Was	an 24b. W	ere autops	y findings available
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/ita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	a enitat-			O+ -		ath (Check only o			
of	Phys r this or	. 7	1√2 Yes 2 No	ospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie			4   Nulsing r	dome 5 ☐ Resident	dence 6XXOther		AT SCENE
ion	nding lath.	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	М	8c. Injury Work 1 🔲 Y	? ′es 2 □ No			_	
Division of Vital Records.	- = = -	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st pecify)	reet, factory	, office		28f. Location (S City or Tox	Street and Number vn, State)	or Rural F	Route Number,
	Hospita 14 hours Funeral	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, deat mination and/or in	h occurred a	at the timing op	e, date and place inion, death occ	e, and due to the curred at the time,	cause(s) and mani date and place, an	ner as stat id due to th	ed. ne cause(s)
	To the vithin 2 To the complex	Me	29b. Signature and title of certifier			1	. License			29d. Date signed		
			> Unesc				0.C.	M.E		DEC. 20	0, 2	.004
	ih		30. Name and address of person who con	*			מים סידי.	ידי סאדים.	TMODE MA	RYLAND 2:	1001	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S		LIMIN S	TIVE	L, DALI.	LUCKE, MA	KILAND Z	LZUL	
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r		1 - For Unpend Item 23a627 per me G840 2-8-05 tas Registrar Certificate of Dea		giene 004 42073
Physicia		1. Decedent's Name (First, Middle, Last) MICHAEL STEWART PASSYN	2. Date of De Month DECEMB	Day Year
/Medic Examin	al er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locatic SALISBURY		ER 20, 2004   8:25p " 4c. County of Death WICOMICO
Funeral Director		214-15-0670 1 1 N 2□F 35 Yrs. Months Days Hour	nder 24 Hrs. 8. Date of Bir urs Min. NOV 2	th year) 969 9. Birthplace (State or Foreig
aryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limit
the Ma	Director	MD WICOMICO SALISBURY  10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
23a or		824 SOUTH SCHUMAKER DRIVE #302 21801		USA
or Items	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Never Married 2 Married 17. Was Decedent Ever in U.S. Armed Forces?  14. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexify Pas 2 No If Yes, Give 1 No Specify Cuban, Mexify Pas, Give 1 No Specify		
be filed within 72 hours ital Hygiene. Id other than "natural", event, Ira Madical Exa	Completed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during n	most of working	16b. Kind of Business/Industry CONSTRUCTION
e filed within Il Hygiene, other than vent, the Me		12 5+ OWNER	lother's Name (First, Middle	REAL ESTATE
	To Be		JLIA ELIZABET	· · · · · · · · · · · · · · · · · · ·
2 should be and Mental is marked reumatic ev		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Address ( <i>Street and Nut</i>	umber or Rural Route Numb	er, City or Town, State, Zip Code)
s 1 and 2 should f Health and Mer Item 27 is marke other treumatic		THEODORE B. PASSYN/FATHER PO BOX 507 TRAP  20a. Method of Disposition (Name of	PPE, MARYLAND	21673 20c. Location - City or Town, State
Pages nent of nt: If It		1 ⊠Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  OXFORD CEMETERY	12-29-2004	OXFORD MARYLAND
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tree		21. Signatural of Fuperal Service Licensee  W. Lewnam W. C.F.S.P. FELLOWS HELF  TO SERVICE LICENSEE  22. Name and Address of Factor Service Licensee  FELLOWS HARRIS	acility	
bur bur	dicai Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Secara of Mary Into Intal Initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C		
	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
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ician: The law re certificate has be ector, page 2 sho	Completed		24a. Was auto perfo 1 XYes	
ysician: is certifica director,	To Be	Hassital:	Nursing Home 5 Pasi	dence .6 XX ther (Specify) SCENE
tending Phy leath. tor: After this the funeral of	ation; T	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2	28d. Describe	how injury occurred
To the Hospitel or Attendin within 24 hours after death.  To the Funeral Director: After completely filled in by the fur	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)
To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date to the basis of examination and/or investigation, in my opinion, and manner stated.	death occurred at the time,	date and place, and due to the cause(s)
Mith To Con	2	29b. Signature and title of certifier OCME	per	29d. Date signed (Month, Day, Year) DECEMBER 21, 2004
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thum 111 PENN STREET,	, BALTIMORE,	MARYLAND 21201
Sta Registra		31. Date filed (Month, Day, Year)  JAN (3 4 2005)  3 Degistrar's Signature		

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artmen: rtificate	t of H	ealth a	and M	lental Hy	giene Reg. No	ma 6/ 1	) 4	42	074
	Physic /Medi		Decedent's Name (First, Middle     JAMES	J.	(	QUEEN					2. Date of De Month DECEME	Da	y 12	Year 2004	3. Time 1	of Death
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	Director		217-36-9391 Usual Residence of Decedent	1 <b>X</b> ] M 2□ F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Decembe	er 24	1920	MARY	LAND	or Foreign
	h the Maryla r 28e-f shov notified at	Director	,	E GEORGE'S	1	LANHAN		Code				10g. Cit	izen of W	Vhat Count	1 🔀 Ye	City Limits
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Maryland 21215-0036	"natural", o	by	3 Widowed 4 Divorced  15. Deceden (Specify only highes	If Yes, Give Year or Da	9	16a. Deced	lent's Usua kind of word	I Occupa	ition	t of work	ing	16b. K	Specify: ind of Bu	BLA		
212 pt	be filed within tal Hygiene. d other than event, it e w	Be Completed	Elementary/Secondary (0-12) 7th 17. Father's Name (First, Middle,	College (1-	4or 5+)	BUILD			VISO	R	e (First, Middle		ERNM			
larylar	2 should be and Mental Is marked a	ToE	WILLIAM  19a. Informant's Name/Relations							r or Rura	al Route Numb		r Town, S	State, Zip (	Code)	
Baltimore, N	ages 1 and 2 nt of Health a t: If item 27 Is y or othar trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		State	Place of Dispo cemetery, cren	sition (Nam natory or ot	e of her place	9)	C	, MARYL	20c. Lo		City or Tow		
Baltin	permit. Pages. Department of H Importent: If ite any injury or ot once.		4 □ Donation 5 □ Other (S <sub>i</sub> 21. Signature of Funeral Septice		RES		. Name and	d Addres	s of Facility	уJ.	7/04 B. JENI LANDOVE	KINS	FUN		HOME	
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Division of		ertification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of	of Injury - At ho g, etc. <i>(Specif</i> )	ome, farm, stre			63 2	113	28f. Location (S City or Tox	Street and vn, State)	d Number	r or Rural F	loute Nun	nber,
	To the Hospital or within 24 hours afte To the Funaral Dis completely filled in	Medical C	one)	g Physician: To the base Examiner: On the base and manner	sis of examina	wledge, death tion and/or inv	occurred a estigation, i	t the time in my opi	e, date and nion, death	d place, a	and due to the dead at the time, of	cause(s) date and	and man place, ar	ner as stat nd due to th	ed. e cause(s	s)
	To the within 2 To the complete	2	29b. Signature and title of certifier  Moune	. Cl	2ler	pa	U I	License				,	5-04	(Month, Da	y, Year)	
	(12)		30. Name and address of person v	JX M.D. 14	314 OLI	MARLE	,	PIKE	UPPE	R MA	RLBORO,	, MAF	RYLAN	ND 20	772	
	Sta Registr	_	31. Date filed (Month, Day, Year)  DFC 1 7 2		gistrar's Signa		E)									

			1 - For State Registrar	State of Ma		epartmer Certificat					giene Reg. No.	004	42075
	<b>D</b>		1. Decedent's Name (First, Middle, Las	t)					2	. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		Clifford Ellis	Rock					De	ecember		2004	9:30 A M
	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City	Town, or	Location of	of Death		4c. Co	unty of Death	
			36 High Street	17.4	. (1aa . la .a b lab		ersto	own If Under:	24 Hrs   0	Data (Dist		ningtor	
	Funeral Director		5. Social Security Number 6. Se	ZM 2□F 81	(In yrs. last birth Yı	Months		Hours	Min.	. Date of Birth (Month, Day	, Year)	Cou	
			Usual Residence of Decedent						LJA	pril 2	3 192	3 Penn	sylvania
	ylanc		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	B-f s	ctor	Maryland Washingt	on	Hagers	stown							1∭Yes 2☐No
	or 28	Directo	10e. Street and Number		_	10f. Zi	Code			1	10g. Citizen	of What Cou	ntry?
	ath w 238		36 High Street				740				.S.A.		
	er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dece If Yes, spe	dent of H cify Cuba	ispanic Orig in, Mexican	gin? (Specit 1, Puerto Ric	fy Yes or No- can, etc.)	14.	Race - Americ Black, White,	
98	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∰ Yes 2 ☐ N If <del>Y</del> es, Give Year or Dates:	lo	1 🗆 Yes	2 No	Specify:			Spi	<sup>өсіfу:</sup> Whit	. 0
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	and 2 lealth m 27		Jane W. Rock / Wi	fe	36	High S	t. H	agers					
ore	of H		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of D cemetery,	Disposition (Na , crematory or o	me of other plac	e)	Dat	9	20c. Locati	ion - City or To	own, State
Ē	Pages Iment of I tant: If it		*4 ☐ Donation 5 ☐ Other (Specify	)	Rest h	aven Ce				04	Hager	stown,	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signal of Funeral Service Licen	900		22. Name a			Kest	Haven	Fune	ral Ch	ape1
_	00 = 6 Q	1 33	mah						nia Av	re Hage	rstow	n Mary	land 21742
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ne cause on each lin	the death. Do no e.	t enter the mod	ie ot dyin	g, such as	cardiac or r	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. meta	rtatie	Can	cia	me	hi	un			1 = 2 mack
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	):							1
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 000	r consequence or,	,.							
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89	death certificate be executed e attending physician and d for use as the burral-transit	by Physician/Medical		<b>u</b> .									
Вох	leath certific attending p	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		۵.					23d.	Date of delive	əry
m.	death e atte id for	icia	in the past 12 months?	1☐Live birth 2 4☐Pregnant at t		3 □Ectopic p 5 □ Other (s <sub>i</sub>						Month	Day Year
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သ	2 55 8	ple	nopulipile	mix						24a. Was a autops	n 24	4b. Were auto	psy findings available mpletion of cause of
Division of Vital Records,	The ate h	Completed								perform	med?	death? 1 ☐ Yes	
ita	Physicien: this certificated director.	Be (	25. Was case referred to medical examiner?						of Death_(C	Check only on	10)		
<u>&gt;</u>	hysik his o	2	1 ☐ Yes 2 No		nt 2 ER/Outp							Other (Specif	y)
Ē	ing P	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day			28c. Injury Work			d. Describe ho	ow injury oc	curred	
sio	Attending ir death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be	00 Phys. (11)	***	M		Yes 2□N	27				10
Ξ	or At fler of Direction by	E	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm . <i>(Specify)</i>	n, street, factor	y, office		281	City or Town		umber or Rura	al Route Number,
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	To the Hospitel or Attending Physicien: The I within 24 burs after death. To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	Medical		rsician: To the best o iner: On the basis of and manner stat	examination and/	or investigation	, in my op	oinion, deat	th occurred	at the time, da	ause(s) and ate and pla	ce, and due to	the cause(s)
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			- ena	2		ī	> (8	019			DEC	27:	2004
	2+1		30. Name and address of person who o	ompleted cause of de	eath (Item 23a) (To	ype, Print)							
j'	34		VASAWT DATT	A MO	r's Signature	MILL	57	HA	a er	STOW	~	m D =	21740
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 25, 2004 Joanne Frances RYAN December /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 108 Birch Knoll Road Washington Hagerstown If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 26, 1937 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) **Funeral** Days 1□ M 2⊠ F Months 67 Yrs. 214-34-0272 Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 108 Birch Knoll Road 21742 U.S.A. filed within 72 hours efter death Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2 ☑ No f Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No white Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker her own home other permit. Peges 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Wiles Merle Margaret Moyer 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) George D. Ryan - husband 108 Birch Knoll, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Dec. 29,2004 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 22 Name and Address of Facility 21. Signeture of Funeral Service Licensee East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that used the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical months Examiner Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funerel director, page 2 should be deteched for use as the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 ☐ Nursing Home 5 X esidence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier (Check only one) 29b. Signeture and We of certifier completed cause of deeth (Item 23e) (Type, Print), of person who ø OM Bay, Year) 32. Registrer's Signature State 2004 Registrar Golfe the

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 2004 1:30 p December 18, Gregory Keith Rager /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Olney Montgomery 17329 Lafayette Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, ) March 19, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1⊠M 2□F Pennsylvania 55 Director 212-54-0204 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worle ?7 is marked other then "naturel", or items 23s or 28e-f ebov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No by Funeral Director Olney Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20832 17329 Lafayette Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes 2 No 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White Yes. Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1.2 should be filed within 7 h and Mental Hygiene.
7 is marked other then "n College (1-4or 5+) Elementary/Secondary (0-12) US Postal Service Postal Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be pehmit. Peges 1 and 2 should be appartment of Health and Menta important: if item 27 is marked any injury or other traumatic evonce. Dolores Brummert Sanford Rager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17329 Lafayette Drive, Olney, Maryland 20832 Bernadette H. Rager - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/2004 Brentwood, Maryland \* 4 □Donation 5 □ Other (Specify) Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 uchelbus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 Years Gastrointestinal Stromal Tumor **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🕅 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 2 📉 No his 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death Certification: 5 Pending investigation 1 X Natural 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pletely filled in by 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time. Medical 29a. Certifier Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D32407 December 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, Rockville, Maryland 20850 MD Joseph M. Haggerty, 31. Date filed (Month, Day, Year) State 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42078 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John McKinley Reed December 2004 17 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 12, 1 Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □XM 2 □ F **Director** 92 Yrs. 217 03 1242 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show other traumatic event. The Medical Examinar must be notified at Director 1 ☐ Yes 2X No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With or Items 23a 3225 Woodstream Lane 21042 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No þ 3 ☐Widowed 4 ☐ Divorced Specify: "natural" White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman Lord Baltimore Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grandview Reed Minerva Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3225 Woodstream Lane Ellicott City, MD 21042 Nancy R. Galloway/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 

Burial 2 □ Cremation 3 □ Removal from State injury or Crest Lawn Mem. Gard 12-20-2004 | Marriottsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Cardiomyopathy years /Medical Due to (or as a consequence of): **Examiner** wonary ortery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ear Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No. Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 NOther (Specify) hos Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 TYes 2 No within 24 hours after death To the Funeral Director; completely filled in by the t 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier December 172004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltemore MD 21204 W 6601 14 31. Date filed (Month, Day, Year) State Registrar 2004 mark.

			For State Registrar	Sta	te of Ma	aryland		rtment tificate			and Me	ental Hyg	jiene leg. No.		L	42	079
	0		Decedent's Name (First, Middle)	Last)							- 2	2. Date of Dea				3. Time o	of Death
п	Physici		David Bren	t	Rain	ev						Month Decembe	Day r 1		9 <b>a</b> r 04	4:30	а м
	/Medic Examin		4a. Facility Name (If not institution,	give street a				4b. City,	Town, or	Location o				County of		1 2 7 0 0	
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	Funeral		5. Social Security Number	6. Sex	1	e (In yrs. la	st birthday)	If Under Months		_		B. Date of Birth (Month, Day	Year)	9.	Birthp	lace (State	or Foreign
П	Director		323-42-5195	1[ <b>X</b> M 2[	_F		50 Yrs.	MOTHES	Days	Hours		une 12	19	54 ]		nois	
_	pu *		Usual Residence of Decedent  10a. State 10b. County			100 City	Town or Lo	antion							14	Od Inside C	20 - 12 - 2
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21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23a or 28a-f ehow ta Madical Evandar must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Y	es, Give ar or Dates	979-8	5	I□Yes 2	2 XNo	Specify:				Specify:	Whi	te	
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and	be fil d otl	Be	17. Father's Name (First, Middle, L									First, Middle,		Sumame)			
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Maryland	d 2 sl th and 7 Is r treur		19a. Informant's Name/Relationsh Mary Sue Rainey		nt)			-				Route Number Isingto				Code)	
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<u>0</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Iteme 23a or 28a-f ehow entry injury or other treumatic event, Ite Medical Evanting must be notified at anote.		1 Burial 2 Tremation		from State		metery, cren tropol			a)   D		per 16,					
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			23a. Part1. Enter the disease, or a shock, or heart failure. List of	o plications	that caused	the death.	Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory arr	est,	<del></del>	-	Approxima	te
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	/Medical		disease or condition resulting in death)  a. Seizure Disorder  Due to (or as a consequence of):											-		-	
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	ecute ind trans	if any, leading to immediate cause. Enter Underlying Cause Disease that initiated events resulting in death) Last Due to (or as a consequence of):  Undiagnosed Possible Cardiac Disease Due to (or as a consequence of):									>						
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87	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d											-		
9 ×	that the death certific ed by the attending p detached for use as	0 1	IF FEMALE:	23c If w	es, outcome	of pregnan	CV										
P.O. Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	10	Live birth Pregnant at	2 Fetal	death 3	Ectopic pre					2	23d. Date of Month		-	Year
o.	the d y the	ysic	1 □ Yes 2 □ No 9 □ Unknown		Unknown	tarre or do	20.	10(1161 (3))	Juny)		-						
	that hed b	by Physician/M	Part II. Other significant condition	s contributin	g to death b	ut not resul	ting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribu	te to th	e cause of	death?
rds	quires n signe ald be	d b	Bipolar Diseas	e, Hyr	erten	sion,						1 🗆 Y	es 28	<b>∑</b> No 3[	] Proba	ably 4 □	Unknown
Vital Records,	s been si should	ompleted	Obstructive Sl	eep Ar	onea							24a. Was a	n	24b. Wer	e autor	osy findings	available
Re	The lav te has age 2	mo									_	autops perfori	ned? ∑X∷No	deal	to con h?	npletion of d 2□ No	cause of
ta	yeician: The is certificate hadirector, page	e C	25. Was case referred to medical							26. Place	of Death (	Check only on			1 85	21110	
>		To B	examiner? 1 □ Yes 2 🔀 No	Hospital	: 1 ☐ Inpatie	ent 2 E	R/Outpatien	3 DO	A Othe			e 5⊠Reside		Other (	Specify	)	
Division of	ding Ph h. After th funeral		27. Manner of Death  txtxNatural 5 ☐ Pending	28a.	Date of Injur (Month, Day	ry y Year)	28b. Time of Injury	28	Bc. injury Work	at		d. Describe ho					
Sio	Attending r death. ector: After by the fune	catl	2 Accident investig	ation				М	1 🗆 Y	'es 2□N	No						
$\leq$	or At after d Direct in by	ertification;	3  Suicide 6 Could n 4 Homicide determine		Place of Injude	ury - At hon c. (Specify)	ne, farm, stre	eet, factory,	, office		28	f. Location (SI City or Town	reet and n, State)	d Number o	r Rurai	Route Nurr	nber,
	Hospital or Attending 24 hours after death. Funerel Director: After tely filled in by the funer	0	20. O. 16.	Dharista	<del>-</del>												-
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier X Certifying (Check only one) 2 Medical E	xaminer: On	the basis of manner sta	f examination	nedge, death on and/or inv	occurred a restigation,	in my op	e, date and inion, deat	d place, an h occurred	d due to the call at the time, d	ause(s) ate and	and manne place, and	r as sta due to	ated. the cause(s	5)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		- Trickinion otc	1 1	,	29c.	License	number		2	9d. Date	e signed (N	fonth, L	Day, Year)	
	N		> Sha	س سم	. 9	HU	le.		DO	04529	6			-		, 2004	1
	101		30. Name an address of person v	no complete	d cause of d	eath (Item :	23a) (Type.	Print)									
			Shamima Abbas,					,	venu	e, Ke	nsing	ton, M	D 20	0895			
40	Sta	1	31. Date filed (Month, Day, Year)	2004	32. Registra	ar's Signatu	ire 4	la	aks	- /							
į	Registr	ar	DEC 16	2004	Acres		10	paper	MARI								

			For Amend Items 2	State of Maryland / Dep 9c, 29d per Dr., G839 Ce	artment of Health and N			42080
			Hegistrar     Name (First, Middle, Last)		Tillicate of Death	2. Date of Death		3. Time of Death
	Physici					Month	Day Yeer	
	/Medic Examin		Lazaro Rober  4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	December 1	4c. County of Death	12:41 PM M
1	LXdiiii		Peninsula Regiona	1 Medical Center	Salisbury		Wicomico	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,		lece (State or Foreign try)
	Director		549-45-2229 Usuel Residence of Decedent	M 2□F 78 Yrs.	Months Days Hours Min.	March 11,		Peru
	hours after death with the Maryland turel', or Items 23e or 28e-f ehow at Exertinet must be notified at	_	10a. State 10b. County	10c. City, Town or L	ocation		1	Od. Inside City Limits
	8a-1-	Director	Maryland Wicomic	o Salisbur	У			1 X Yes 2 □ No
	or 2	Dire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coun	try?
	ath w			Apt. 3	21804		USA	
	er de	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1  Yes 2□ No Specify:		Specify:	
21215-0036	hou	edt	15. Decedent's Edu		Pel  dent's Usual Occupation	cuvian	6b. Kind of Business/Ind	spanic
15	n ne	plet	(Specify only highest grade	e completed) (Give	kind of work done during most of work DO NOT use retired)	ing	ob. Killa of Dasillessville	iustry
212	yith Diene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)  Reta	il Manager		Cosmetic St	ore
פ	e file of he vent,	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		.010
<u> a</u>	Aenta Aenta rked ric e	To E	Lazaro	Rosales	Sophia		Ortiz	:
Maryland	and h		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Maili	ng Address (Street and Number or Rur	al Route Number, (	City or Town, State, Zip	Code)
Ž	and 2 palith n 27 i		Joseph Luis Rosale	s (son) 1011	Granite Court, Sai	lisbury,	Maryland 2	21804
ore	of He fitsn r oth		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ R	20b. Place of Disponential Commencer	osition (Name of matory or other place)	Date 20	Oc. Location - City or To-	wn, State
Ĕ	Pag ment ant: i ury o		'4 □ Donation 5 □ Other (Specify)		y Crematory December	c 16, 2004	Salisbury,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportent: If item 27 is marked other than "natural," or items 23e or 28e-1 show any injury or other traumatic event, It is Madical Examiner man be notified at once.		21. Signature of Funeral Service Lightse	700	lane and Address of Eacility Ho	ome Profe	ssional Ass	ociation
ш	80 E B 0	10	X SULTU	1/17/2 5	Ol Snow Hill Road	Salisbu	rv. Marylar	
	· •		23a, Part 1 Enter the disease, or compli shock, or heart failure. List only or	cations that caused the drath. Do not en	ter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cololsin	e Heart Fa	ilump	1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a sequenca of):	и	14		
		_	Sequentially list conditions, b	Commy	Actory 1	Leal	ce	
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Offices or injury that initiated events	Due to (or as a consequenca of .	,			
_	and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a consequence of):				
760,	icate be executed physician and s the burial-transit	calE		550 to (or as a consequence of).				
		edlo	0					
×	death certificate attending phy of for use as the	/We	IF FEMALE:	3c. If yes, outcome of pregnancy			22d Date of deliver	
Вох	atter I for u	clar	in the past 12 months?	1 Live birth 2 Fetel death 3 □	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	y Day Year
o.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				
0		by PI	Part II. Other significant conditions con	stributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the	cause of death?
Records,	quires in signa	b d	Poly ma	lara Cheur	ratics	1 🗆 Yes	2 □ No 3 □ Proba	biy 4/XJUnknown
00	law requir as been si 2 should I	Completed	10/50/00	Il Marcel	an Dicease	24a. Was an	24b. Were autop	sy findings available
æ	ician: The la certificate has rector. page 2	mo	1/2	100		autopsy performe 1 ☐ Yes 2 2	prior to com	pletion of cause of
		0	25. Was case referred to medical examiner?	1 denia	26 Place of Deatl	1 Yes 22 (Check only one)	No 1 □ Yes	2 LI No
		To B	examiner? / 1 Tes 2 DNo	ospital:	Other		ce 6 Other (Specify)	
0	ding Phys		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how		
0	tendin death. tor: Af the fur	atic	1 ✓ Natural 5 ☐ Pending investigation	(Month, Day 1 day	M 1 Yes 2 No			
Division of	I or Attendate death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, offica	28f. Location (Stree City or Town, 5	et and Number or Rural	Route Number,
	itat o irs aft rai Di							
	To the Hospitat or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  2 Medical Examin	sician: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as sta and place, and due to	ted. he cause(s)
	To t To t	Σ	29b. Signature and title of certifier	- A /	29c. License number	29d	. Date signed (Month, D	ay, Year)
)			Cotten	- he Home	D45005	Jan	nuary 7,200	5
	i MH		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type,	Print)			
/	1 11 10		Dr. Catherine Horne	er 1346 South Di	vision Street, Sal	isbury, 1	Maryland 2	1804
ge.	Sta Registra	te ar	31. Date filed (Month, Day, Year) DEC 16 200	32. Registrar's Signature	pack			

		1 - For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment of H	ealth D <i>eath</i>	and Men		giene2 ()	04	42081
DI VIV		1. Decedent's Name (First, Middle, Las	(t)					Date of Dea	ith Day	Year .	3. Time of Death
Physicia /Medic		MARIA L	RIVAS					12		Zouy	OUZU AM
Examin		4a. Facility Name (If not institution, give Washington Adv	estreet and number) entist Hospita	11	4b. City, Town, or Takoma				4c. County Prin		eorges
Funeral Director		5. Social Security Number 578-21-3858 6. Social Security Number 1	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (	Date of Birti Month, Day	, Year) 1912	Coun	place (State or Foreign otry) Salvador
pu k		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	cation					1	0d. Inside City Limits
Aaryle f sho	ō	Md. Prince	Georges Hy	attsv	11e						1 ∑Ses 2 □ No
filed within 72 hours after death with the Maryland Hygiene. Hygiene street street street street then "neture!", or ttems 23a or 28e-1 show ent, the Marchall Examination street in tiling.	Director	10e. Street and Number 404 Greenlawn D	r.		10f. Zip Code 20783				10g. Citizen of V		itry?
ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.		Was Decedent of Hi	spanic Or	rigin? (Specify	Yes or No-	,	e - Americ	an Indian,
ours after death wit rel', or Items 23a c	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☑ Yes 2 ☐ No	n, Mexica Specify				ck, White, o	
72 hou	ted	15. Decedent's Ed (Specify only highest gra	lucation		dent's Usual Occupa		st of working	ì	16b. Kind of Bu	usiness/Inc	dustry
be filed within 72 ho ital Hygiene. d other then "netu event, It e M. dical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,	)	st of working				
iled w tygier ther ti		3rd  17. Father's Name (First, Middle, Last)		House	keeper	18 Moth	ner's Name /Fir	et Middle	Self-E		yed
d be feat the section of the section	o Be	Mercedes Sanche					aria Pe			6)	
shoul nd Me mari umeti	Ţ	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailin	ng Address (Street a Preenlawn	and Numb	oer or Rural Ro	ute Numbe	r, City or Town,	State, Zip	Code)
and 2 alth a 27 is er tre		Rubertina Rivas	(Daughter)	Hyati	sville, I	Driv Mary]	ye #202 Land, 2	0783			
es 1 a of He fitem r oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	1 6	lace of Dispo	sition (Name of natory or other place	- 1	Date		20c. Location -	City or To	wn, State
. Pag tment tent: jury o		`4 ☐ Donation 5 ☐ Other (Specify	) Gat	e of 1		i	12-20-	04	Silver	Spri	ing, Md.
permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene traportent: If item 27 is marked other then "in any injury or other treumetic event, Item 2000.		21. Signature of Fun ral Service Licen	see Bacin CC 34		W. H. Bac 3447 14t	con l	Funeral	Home Wa	, Inc.	n, D.	. C. 20010
		23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the deat one cause on each line.	n. Do not ent	er the mode of dying	g, such as	s cardiac or res	piratory ar	rest,	CHEST CO.	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. SERSI	\$							Onset and Death
/Medical Examiner		Tooling in assum	Due to (or as a conseq	uence of):							
GIA.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):							
be executed sician and burial-transit	Examiner	that initiated events	С.								
ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):							
the the	dicai	•	d								
Se as	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incv					22d Dat	to of doling	201
The law requires that the death certific the law requires that the death certific page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)				Moi	te of delive nth	ny Day Year
res that igned by	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part	I.	23e. Did to	bacco use contr	ribute to th	ne cause of death?
w require: been sig should bo	ed p	ischijdravan						1 □ Y	es 2□No	3 Proba	ably 4 Honknown
has bee	Completed	<u> </u>						24a. Was autop		Nere autor	psy findings available mpletion of cause of
The ate ha	Com							perfor	med?	death?	•
Physicien: r this certific	Be (	25. Was case referred to medical examiner?	Hospital:		Othe		e of Death (Ch	eck only o	ne)		
Physical direction	10	1 Yes 2 100	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time o		4 🗆 IV			ence 6 Othe		1)
ding h. After funer	tlon	1	(Month, Day Year)	Injury	Work			Describe II	ow injury cocurs	ou	
Atten r deat actor: by the	ifica	3 Suicide 6 Could not b	28e. Place of Injury - At he	ome, farm, sti	eet, factory, office				treet and Number	er or Rura	l Route Number,
s affe	Certification:	4  Homicide determined	building, etc. (Specif	<i>y)</i>				City or Tow	n, State)		
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical (		ysician: To the best of my knoniner: On the basis of examina and manner stated.								
To th within To th comp	M	29b. Signature and title of certifier			29c. License	number		2	29d. Date signed	1 (Month, I	Day, Year)
01		Fri Onda			354	127			12-13	3-200	1
- (!) \		30. Name an address of person who	completed cause of death (Item	-	Print)	0 7	Mean		enc mi	0	
Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa					1 1.40	11		
Registi		DEC 1 7 200	Bleen &	ho	de			1			
DHMH 17 Rev 1/2	001			-							

DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 2 0 8 2
I	Physici /Medi		1. Decedent's Name (First, Middle, Last)  ROLAND RANDALL  2. Date of Death Month Day 12:01PM M
	Examir Funeral Director		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Fort Washington Medical Center  Fort Washington  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Months Days Hours Min.  7. Age (In yrs. last birthday)  Months Days Hours Min.  1. Day (State or Foreign Country)
	g	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  MD Prince George's Fort Washington 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	th with the 23a or 28e- ust be notifi	<b>Funeral Director</b>	10e. Street and Number 1202 Livingston Road 10f. Zip Code 20784 10g. Citizen of What Country? USA
036	be filed within 72 hours after death with the Maryland nat Hygiene. 3d other than "naturel", or Items 23a or 28e-1 show event, the Medical Examination ust be rediffed at	þ	11. Marital Status    1
21215-0036	i within 72 hours iene. r than "naturel", the Medical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  11  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired)  Brick Mason  Construction
	ta de la pe	To Be C	17. Father's Name (First, Middle, Last)  Joseph K. Randall  18. Mother's Name (First, Middle, Maiden Sumame)  Marie Bell
	1 and 2 Health a em 27 Is ther trai		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Constance R. Plater/sister  520 Little Brook Drive, LaPlata, MD 20646  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of Importent: If it eny injury or o		1  Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place)  1  Onation 5 Other (Specify)  Cedar Hill Cemetery 12/18/2004 Suitland Md.  21. Signature of Funeral Service Licenses  22. Name and Address of Facility Capitol Mortuary, Inc.
-	Pnysician /Medical Examiner		23a. Part 1. Enter the disease of complications that caused the death. To hot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  ATHEROSCLEROTIC CARDIOVASCUAR DISEASE  Due to (or as a consequence of):
	tificate be executed g physician and as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):
, DOX	ath cer	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 23d. Date of delivery Month Day Year
cords, r	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Sunknown
אוומו שבני	an: The law ificate has b	e Completed	24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical  26. Place of Poeth Wheely at Novel
5 8	I of the Nospital or Atlending Physicien: The law requires that the dewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to	Certification; To B	examiner?  1
5	I ofthe Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Certi	29a. Certifier (Check only)  29a. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
,	vithin 2 To the	Med	29b. Signature and title of certifier  PHYSICIAN  29c. License number  29d. Date signed (Month, Day, Year)  DCC 7 <sup>th</sup> 2004.
- (			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SVKESM VOLGNUSE 11701 LIVINGSTON ROAD, SUITE #101, FORT WASHINGTON  31. Date filled (Month, Day, Year) 3. Registrar's Signature
H	Stat Registra		31. Date filed (Month, Day, Year)  DEC 1 7 2004  Registrar's Signature  Aparle  MD.

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of L			ene 00	4 42	083
	Physic	ian	1. Decedent's Name (First, Middle, L			-		2. Date of Death Month	Day	Year	ne of Death
	/Medi	cal	Mimie L. Rt  4a. Facility Name (If not institution, or			4h City Town	Landing (Dec	December		004 6:3	37 P M
	Exami	ner				4b. City, Town, or			4c. County of		
Н	<u> </u>		Holy Cross I  5. Social Security Number 6.		ge (In yrs. last birthday		er Spri			ntgomery	
	Funeral Director		422-44-9710	1□M 2∏F	68 Yrs.	Months Days	Hours Min		Year) 1936	9. Birthplace (St Country) Alaban	ate or Foreigi 1 <b>a</b>
	pur ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L						
	Maryla 1-f sho	to		e George's	Toc. City, Town of L		t Heigh	ts			de City Limits Yes 2 □ No
	with the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?	
	s 23a	ra	5524 Addison				20743			ed State	-
200	ba filed within 72 hours after death with the Maryland ital Hygiene. Id other than "neturel", or Itams 23a or 28a-f show event, I've Medical Event and trust be traited at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 27 If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American India White, etc.	n,
21212-0036	72 hou	Completed	15. Decedent's 8	ducation	16a. Dece	dent's Usual Occupa	tion	,. 1	6b. Kind of Busi	Black ness/Industry	
V	within 7 ene. than "r	nple	(Specify only highest gi	College (1-4or	life	kind of work done of DO NOT use retired,	uring most of wo	orking		,	
	filed withi Hygiene. other than	So		4		Map	agement			vate	
₹		Be	17. Father's Name (First, Middle, Las				18. Mother's Na	me (First, Middle, M	aiden Sumame)		
Maryland	should ba nd Mental markad o umatic eve	Ţ0	Jimmy V						tha Ande		
<u>0</u>	d 2 sho th and 7 Ismu traum		19a. Informant's Name/Relationship  Johnny L. Dut					dural Route Number,			
ב ת	is 1 and 2 should of Health and Mer item 27 Is marks other traumatic	3	20a. Method of Disposition			osition (Name of matory or other place		Cheverly,	MD 207 0c. Location - Ci		e
	permit. Pages Department of i Important: If ite eny injury or of		1 🗷 Burial 2 □ Cremation 3 [  '4 □ Donation 5 □ Other (Spec		1		1	22/2004	Bront	wood. M	D
parlimore,	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service Lice	nsee A		2. Name and Addres		Stewart I			Б
	90E 29		John 1. 5	Jewail.	111	4001 Ben	ning Rd	., N.E. Wa	sh., DC		
. 1	nysician	0. 12. h	23a. Part Enter the disease, or con shock or heart failure. List only Immediate Cause (Final disease or condition	one cause on each ii	ne.				st,	Approxi Interval Onset a	mate Between and Death
	/Medical Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. EWD S	a consequence of):	REWAL	DISEA	RETION		m	enths
,00,100	ficate be axecuted physician and s the burial-transit	edical Examiner	Cause (Triesder of Injury that initiated events resulting in death) Last	Due to (or as	a consequence of):						
YOU .	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,	Year
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	ilcien: The law requicentificate has been rector, page 2 should	Completed						24a. Was an autopsy performe	prio dea	re autopsy finding to completion of th?	gs available of cause of
=	siciel certil recto	o Be	25. Was case referred to medical examiner?	Hospital:		Other		ath (Check only one)		_	-9-
5	to the thospitel or Attending Physicien: The within 24 hours after death.  To tha Funerel Diractor: After this certificate h completely filled in by the funeral director, page	-	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Inju (Month, Da	ry 28b. Time of	28c. Injury Work	at	10me 5 Resident 28d. Describe how		(Specify)	
;	itel or Attenors after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number o State)	or Rural Route N	umber,
	To the Hospitel within 24 hours a To tha Funerel C completely filled	edical	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of miner: On the basis of and manner sta	of my knowledge, death examination and/or in- ated.	occurred at the time vestigation, in my opi	, date and place nion, death occu	e, and due to the cau arred at the time, date	se(s) and manne and place, and	er as stated. due to the caus	e(s)
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			M. Fr	rage		D-	1787	4	12-16	-04	
_	(4)		30. Name and address of person who S. M. NAY A.C. 31. Date filed (Month, Day, Year) DEC 2 0 2004	completed cause of d	eath (Item 23a) (Type,						2
	Sta Registr	te ar	31. Date filed (Month, Day, Year) DEC 2 0 2004	2. Registra	ar's Signature	le					

		•	For State Ragistrar	State of Ma	aryland / I		tment of F ficate of i	lealth and N <i>Death</i>	_	giena Reg. Na	IIII	42084			
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)		0	1 -		2. Date of De. Month			3. Time of Death			
	/Medic	al	4a. Facility Name (If not institution, giv	HNDE	ER	KAT	NER	a Leasting of Dooth	12	14	1 200	+ 13:15PM			
40	Examin	er	-//	NAI MINI	cal Co	150		r Location of Death	/	40	County of De				
	Funeral		5. Social Security Number 6. S		(In yrs. last bi	- 1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year,	9. B	irthplace (State or Foreign Country)			
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	ryland how		10a. State 10b. County		10c. City, Tow	m or Loca	tion					10d. Inside City Limits			
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	with the or 2	Dir	1702 Eastgate	Drivo #	505		10f. Zip Code 21804	4			itizen of What C	Country?			
	death	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		13. Wa		t lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		.S.A. 14. Race - Arr	erican Indian,			
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Bd other than "natural", or items 23a or 28a-f show event, the Medical Examirat must be indiffed at event, the Medical Examirat natal be indiffed at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo		es, speciny Cuba DYes 2.DXNo	Specify:	Hican, etc.)		Black, Wh				
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yla	2 should be and Menta is marked sumatic ev	70	Abraham Ande						Ratnei						
Maryland	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship ( Laurie Schwa	* * * * * * * * * * * * * * * * * * * *		_		and Number or Rur Post Rd		. ,		,,			
	1 a Hea man the		20a. Method of Disposition		20b. Place of	of Disposit	ion (Name of tory or other place		Date		ocation · City o				
Baltimore,	ry ry		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif			-	ley Vi	1 1 2 / 1	.7/ 04	Las	s Vega	, NV			
Balt	permit. Page Department Important: any injury once.		21. Signature of Funeral Service Dicer	bey		He	Name and Addre olloway 01 Snov	ss of Facility Y Funera W Hill F	l Home	e alis	sburv.	MD 21804			
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ion	Attanding F r death. actor: After i by the funera	atior	1 □Natural 5 □ Pending 2 □ Accident investigatio		Year)	Injury	Wor	k? Yes 2 □ No							
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	he Ho in 24 h ha Fu pletely	edicai	(Check only 2 Medical Example)	miner: On the basis of and manner sta	examination a	nd/or inve	stigation, in my o	pinion, death occur	red at the time,	date an	d place, and du	ue to the cause(s)			
<b>\</b>	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Moi	nth, Day, Year)			
	100		30. Name and address of person who	completed cause of d	eath (Item 23a)	(Type Pr	int)	7127			14114	104			
6	ing		ALGO DAVIS N	10	n On	32V	St.	Selist	oury	V	NO 7	1804			
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096-20-7705

Shirley Ratner

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		1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of F	lealth and Death		giene	04	42085
Physic /Medi		1. Decedent's Name (First, Middle, Last	ichen wal	Iner			2. Date of De Month	ath Day	Year	3. Time of Death
Examil		4a. Facility Name (If not institution, give linibulo light) 5. Social Security Number 6. Se	street and number)  Au Nedich (  x 7. Age (In yrs. 1)	enter	4b. City, Town, o	ISDULY  If Under 24/Hrs Hours Min.	8. Date of Bir	th	of Death COTM  9. Birthpl	lace (State or Foreign
Director		591-14-8572  Usual Residence of Decedent  10a. State 10b. County	M 2⊠F 38	Yrs.		Tious William			West	Virginia  Od. Inside City Limits
ith the Marylan or 28e-f show	Director	Maryland Wicomic		lisbur				10g. Citizen of		1 XYes 2 □ No
"natural", or Items 23e or 28e-f show	by Funeral Dir	703 Edgewater Dri 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Ve #104 12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 25 No If Yes, Give Year or Dates:	l l	21804 Was Decedent of H	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	USA	ce - America ck, White, e	an Indian, etc.
	Completed t	15. Decedent's Edu (Specify only highest grad	ication	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired	pation during most of wo d)	rking	16b. Kind of B		
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C, Mal yio	2	Laine 19a. Informant's Name/Relationship (7)			g Address (Street		ural Route Numb		, State, Zip	Non-Levin
		Mark Reichenwalln  20a. Method of Disposition  1 □ Burial 2 🖫 Cremation 3 □ I	20b. P Removal from State	lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date	20c. Location	- City or Tov	
permit. Page Department of Importent: If any injury or once.		* 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licenses)		H	Name and Addre	ss of Facility Tuneral H	Home Pro	fessiona	al Ass	Maryland sociation ad 21804
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	hysiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)	1			ate of deliver	ry Day Year
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending investigation	Hospital: 1 Hipatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur	er: 4 Nursing l	ath (Check only of Home 5 Residence 28d. Describe		1. //	)
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To the within To the comp	W	29b. Signature and title of dertifier			29c. Licens	56197		29d. Date signe	d (Month, D	Jay, Year)
214)		30. Name and address of person who o	ompleted cause of death (Item	23a) (Type,	311	ST SX	is by M	15-218	(0)	l)
St Regist	ate trar	31. Date filed (Month, Day, Year) DEC 1 4	2004 32. Registrar's Signa	iture	& space	Ks	)			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1845 M Doris Jane Stoner December 22 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hagerstown Washington County Washington County Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M X F Months Days Yrs. 73 December 27 1930 Maryland Director 218-24-1426 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other then "naturel", or Items 23a or 28a-f show treumatic event, the Madical Experiment was be notified at 1 ☐ Yes X No Directo Maryland Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21740 330 Daycotah Ave death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Personal Residence Homemaker 10 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill iment of Health and Mental H tent: If item 27 is marked other Beatrice Shoemaker Peter Moser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert William Stoner, Sr. (husband) 330 Daycotah Ave. Hagerstown Maryland 21740 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: If any injury or once. ŏ Hagerstown Maryland 12-27-04 REst Haven Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Fastern Blvd., N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760 Be Completed by Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 2 0 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b Time of 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature an titla of certifier 1)0022043 completed cause of death (Item 23a) (Type, Print) Campus Rd Hagerstown Wooster 11116 Medical 32. Registrar's Signature 31. Date filed (Month, Day, Year) Carlin Stand Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene of All

			For State Registrar	State of Mary	and / Depa Cer	rtificate of I	leaith and iv Death		giene () ()	4	42087
	Physici	an	Decedent's Name (First, Middle, Last)	<b>a</b>				2. Date of Dea	Day	Year	3. Time of Death
	/Medic		Brian War 4a. Facility Name (If not institution, give s	yne Stewart		4h City Town or	Location of Death	Decemb	er 1/, 2	004	4:55 P <sup>M</sup>
	Examin	er	Hospice of Balti		st		imore		vo. obumy	or Dodin	
	Funeral Director		5. Social Security Number 6. Sex 218-66-3064	7. Age (In )	rs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 22	h y, Year) , 1955	9. Birthpli Count Mary	ace (State or Foreign try) Land
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10	Od. Inside City Limits
	Many -f sh	to	MD Harford		Havre I	e Grace					1 ☑ Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Count	ry?
	23a c	aiD	123 Wilson Stre	et		2107	8		U.S	5.A.	
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or Items 23e or 28e-f show event, I're M. Jicel Ess nitrat must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	- 14. Race Black Specify:	- Amenca c, White, e Wh	
ည်	72 hc	etec	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	dent's Usual Occup	ation during most of work f)	ing	16b. Kind of Bus	siness/Ind	ustry
2	filed within 72 Hygiene. kther than "nal	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	<i>DO NOT</i> use <i>retired</i> earch Sci			Priva	ite	
	filed Hygie Sther I		17. Father's Name (First, Middle, Last)		1000	Jaren Ber	18. Mother's Name	e (First, Middle,			
yland	2 should be and Mental Is marked o	To Be	Virgil Stewart				Se1by	Johns			
Mary	should and Men s marke rumatic	-	19a. Informant's Name/Relationship (Ty	οθ, Print)	19b. Mailir	ng Address (Street	and Number or Run	al Route Numbe	er, City or Town, S	State, Zip	Code)
	es 1 and 2 should to of Health and Ment fitem 27 is marked rother traumatic e		Christina Trevath			Wilson S			Grace MI	210	78
Baitimore,	Jes 1 of He If iter or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R			sition (Name of matory or other place		Date	20c. Location - 0		
	tment tant:		`4 ☐ Donation 5 ☐ Other (Specify)	F			tery 12/2		Brentwoo		
Ra	permit. Pages Department of I Important: If its any injury or of once.		21. Signature of Funeral Syrving License	<del>90</del>			ss of Facility For ensburg R				
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O. Box	death cer e attendir id for use	by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	]Ectopic pregnancy ] Other (specify)			23d. Date Mon	of deliver	ry Day Year
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ō	<u>a</u>		1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time of	11 3 DOX	4   Indising no		now injury occurre		Notpia
5	nding I	alor	Y⊇Natural 5 ☐ Pending	(Month, Day Yea	r) Injury		k? Yes 2 □No				
Division of	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, streecify)	reet, factory, office		28f. Location (5 City or Tox	Street and Numbe vn, State)	r or Rural	Route Number,
	e Hospital 124 hours e Funeral letely filled	edical (	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death nination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mar date and place, a	ner as sta nd due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed		
)			Myllanly	CV)		15	8303		Decem!	200 (	7 2004
2	(6)		30. Name and address of person who co	empleted cause of death (	(Item 23a) (Type,	Print)	- Bulti	nore U	10 212	04	7 2004
	Sta Regist	_	31. Date filed (Month, Day, Year)  DEC 2 1 2004	3 Registrar's S		ule					

Bam Se 14/7/2

			For State Registrar	State	e of Ma	ryland .	/ Depa	rtment of H tificate of L	ealth a	and Me	ental Hyg	giene Reg. No.	2004	42088
			1. Decedent's Name (First, Mic	dle, Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		JOHN R	OBERT			STOCE	KS			Decembe		16 2004	4:05 A M
	Examin		4a. Facility Name (If not institu	ion, give street an	d number)			4b. City, Town, or	Location of	of Death		4c.	County of Death	
			SOUTH RIVER N					EDGEWATE					NE ARUNI	
	Funeral		5. Social Security Number	6. Sex 11∑ M 2□		(In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birtl (Month, Day	(Year)	9. Birth	place (State or Foreign ntry)
	Director		241-62-6133 Usual Residence of Decedent		. 00		115.				March 1	5 19	944 NORTI	H CAROLINA
	and and		10a. State 10b. Cour	ity		10c. City, T	Town or Loc	cation						10d. fnside City Limits
	Mary f sho	ō	MD ANNE	ARUNDEL		SH	IADY S	SIDE						1∰Yes 2☐No
	the 28a	rec	10e. Street and Number					10f. Zip Code				10g. Citi:	zen of What Cou	ntry?
	3a or	Funeral Director	5312 AL JONES	DRIVE				20764				U.S	.A.	
	death ms 2	Jera	11. Marital Status	12. Was	Decedent E	ver in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Ori	igin? (Spec	ify Yes or No-		14. Race - Ameri Black, White,	
9	or Ite		1 ☑ Never Married 2 ☐ N	arried 1 🖾	Yes 2 ☐ N s, Give	lo		Yes 2 No	Specify:		iloan, etc.)		Specify: B1a	
8	d within 72 hours after death with the Maryland Joons. Ir then "natural", or Items 23a or 28a-f show The Madical Examinational the nicility of all	d by	3 ☐ Widowed 4 ☐ Divord	ed Year	or Dates:									
5	72 h "natu	Completed		ent's Education hest grade comple	eted)	1	(Give	lent's Usual Occupa kind of work done o OO NOT use retired	during mos	t of workin	g	16b. Kir	nd of Business/Ir	ndustry
12	within lena than "	ш	Elementary/Secondary (0-12	.) Colfe	ege (1-4or 5			Driver	'/			D		
2	e filled v of har f vant, II		12th 17. Father's Name (First, Midd	le. Last)			Truck	Driver	18. Mothe	er's Name	(First, Middle,		.vate Sumame)	
ano	@ g th g	o Be		ocks Sr.					Jess	ie R.	Simmo	ns		
Maryland 21215-0036	s 1 and 2 should be f Health and Mental item 27 Is markad othar traumatic ev	은	19a. Informant's Name/Relation		t)		19b. Mailin	g Address (Street a					r Town, State, Zij	p Code)
	nd 2:		Gladys M. St	ocks/Daus	ghter		2015	20th Stre	eet F	t. Me	ade, M	ary1	and 2075	55
ē,	es 1 and 2 of Health fitem 27 I		20a. Method of Disposition			20b. Plac	e of Disponence	sition (Name of natory or other plac	е)	Da	ate	20c. Lo	cation - City or T	own, State
Ē	Pages nent of int: If it iry or o		1 ⊠Burial 2 ☐ Cremation 3 ☐ Other		trom State	Mary1	land	Veterans		12/28	/04 (	Chel:	tenham,M	laryland
Baltimore,	permit. Pages Department of Important: If i any injury or one		21. Signature of Fune al Serv	ce Licensee	7		22	. Name and Addres	ss of Facili	ty J.	B. Jen	kins	Funera	1 Home
Ω	88 = 8		1		0			74 Lando					iaryland	20785
U			23a. Part1. Enter the disease shock, or heart failure.	or complications ist only one cause	that caused on each fin	the death. le.	Do not ente	er the mode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician		fmmediate Cause (Final disease or condition	Ca	ancer	Bladd	er						9	Onsot and Dodgi
	/Medical Examiner		resulting in death)			a consequer	nce of):							
	ZXGIIIIICI	-	Sequentially list conditions,	b	etasta	ASIS a consequer	nce of).						-	
	tad	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	< "	20 10 101 401	a 501150quo.								
	be executad sician and burial-transit	Examin	that initiated events resulting in death) Last	C. Di	ue to (or as a	a consequer	nce of):							
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit			d.										
9	tificate g physi as the l	Physician/Medical		_							alic-la-Walla	-		
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant			of pregnance		Ectopic pregnancy	,			2	23d. Date of deliv Month	ery Day Year
	e deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗆		time of deat		Other (specify)					MOUTH	Day
P.0	that the de led by the detached	Phy	9 Unknown Part II. Other significant cond	Utlana contributio	a to dooth bu	ut not ropulti	na ia tha	adorhina anusa aiu	on in Part I		23e Did to	phacco II	se contribute to	the cause of death?
S,	res the	by	Part II. Other significant com	intons commoning	g to death bt	at not resulti	ng III tilo u	idanying cause give	917 III T GITT	1.				bably 4 🛣 Unknown
ecords,	w require been si should I	eted									E W	- 22	National Control	
Rec	elaw has b	Completed				<u>-</u>	·				24a. Was autop perfo		prior to co	opsy findings available empletion of cause of
alF										15 11	1 ☐ Yes	20C] No	1 🗆 Yes	2x No
Vital		o Be	25. Was case referred to med examiner?	Hospital:	1 🗆 Innatio	nt 2□EF	2/Outpation	t 3 DOA Oth	00		(Check only o		6 □Other (Speci	iful
of		1	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a.	Date of Injur	ry 28	8b. Time of	28c. Injun	y at	-	8d. Describe h			'Y)
on	Attanding I r death. actor: After by the funer	tlor	1 X Natural 5 ☐ Per 2 ☐ Accident inv	nding estigation	(Month, Da)	y Year)	fnfury	Worl M 1□	k? Yes 2. ☐	]No				
Division	l or Attandi after death. Diractor: A	ifice	3 ☐ Suicide \ 6 ☐ Co	uld not be ermined 28e.	Place of fnit	ury - At home	e, farm, str	eet, factory, office		2	8f. Location (S City or Tox			ral Route Number,
Ö	s after s after al Dira	Certification;	4 _ Nomicios		building, all	c. (Specify)							, 	
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	edical	29a. Certifier (Check only one) Certi	cal Examiner: On	To the best of the basis of manner sta	examination	edge, deatl n and/or in	n occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the old at the time, o	cause(s) date and	and manner as a place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tyle of cel	ifier				29c. Licens	e number			29d. Dat	e signed (Month,	. Day, Year)
	5		<b>)</b> // /	1				D5702	28			12/1	7/04	
0	(6)		30. Name and address of per							7.6	34 3	1	21/01	
	9		Aditya Cho					nue # 231	Anna	abo11	s maryl	Land	21401	
	Sta Regist	atė rar	31. Date filed (Month, Day, Y	2004	Cov.	ar's Signatur	April	le						

JAMES	STROUSE		1 - State Unpend Ite	State of	of Marylar	d Dep	artment of H	lealth and	Mental Hy	giene	nnı.	1, 21	089
					H, HMW, McCo	Ce	tificate of	Death	2. Date of De		004	3. Time of	
	Physicia		Decedent's Name (First, Middle     James George S						Month DEC.	Day 26,	Year	3:40	P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	ımber)			or Location of Deat		4c. Cc	ounty of Death		
0			5204 KENESAW S				COLLEG				INCE GE		
9	Funeral Director		5. Social Security Number 213-80-1727	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs.	43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		ay, Year)	9. Birth Cou Penn	place (State d intry) ISY1van	or Foreign nia
T			Usual Residence of Decedent						1-001 0	,			
	arylan show	ž	10a. State 10b. County			ty, Town or Lo	ocation					10d. Inside C 1 ☐ Yes	ity Limits 2 (XNo
	the M 28a-1	recto	Maryland Pr	ince Geor	ge's	Co	ollege Pa	20740		10g. Citize	n of What Cou		
	h with 23a or	al Di	5204 Kenesaw	Street			-2063	<del>6-</del>		US.	A		
	tems	Funeral Director	11. Marital Status	Armed F		J.S. 13.	Was Decedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14.	. Race - Ameri Black, White		
36	irs afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 🌴 ☐ Divorced	ed 1 ☐ Yes If Yes, G Year or I	2 <b>X</b> No ive Dates:		1 ☐ Yes 2 <b>%</b> No	Specify:		Sį	<sub>pecify:</sub> Whit	te	
21215-0036	72 hou	eted	15. Decedent (Specify only highes	's Education	)	(Give	dent's Usual Occup	during most of wo	orking	16b. Kind	of Business/Ir	ndustry	
121	within and.	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retire	d)	· ·	Firem	iture		
	filed v Hygie other I	ø	12 17. Father's Name (First, Middle, I	Last)		1 50	les	18. Mother's Na	me (First, Middle	1			
/lan	wild be Mental wrked atic ev	To B	George H. Str	ouse				Marcel	la H. Lu	ıke			
Maryland	and Is ma		19a. Informant's Name/Relationsh				Grand fi			-			0004
	Pea a		George H. Stro	use/raciie		and the same of th	Gracefic esition (Name of matory or other pla		Date	20c. Loca	tion - City or T		3304
Õ	Pages nnt: Hi		1 ☑ Burial 2 ☐ Cremation  1 ☐ Donation 5 ☐ Other (S)		State	Gate of Cemet	Heaven	DCC	ember 31 2004		r Sprin	ng, Ma:	ryland
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ott		21. Signature of Funeral Service	Licensee	) _	2 F	Name and Addre						
	20 E e o		23a Part 1 Enter the disease of	con plications that	caused the dea		00 Unive				Spring	g, MD 20 Approximat Interval Bet	
	Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final				hronic A					Onset and	lween Death
	/Medical		disease or condition resulting in death)	a	(or as a conse		in onic n.	reonorio	4				
	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conse	quence of):							
	uted d ansit	Examiner	Cause (Disease or injury that initiated events		(	,							
0.	te be executed ysician and ie burial-transit		resulting in death) Last	Due to	(or as a conse	quence of):							
8760	y y	dlcai		d									
Box 68	death certificat e attending phy of for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		∃Ectopic pregnanc	20		230	d. Date of deliv	*	
	0 00	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		gnant at time of		Other (specify)	·)			M <i>o</i> nth	Day	Year
0	that the ed by th detache		Part II. Other significant condition	ons contributing to	death but not re	sulting in the t	inderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of	death?
r o	requires ween sign hould be	ed by							1 🗆	Yes 2□	No 3□Pro	bably 4 🗆	Unknown
900	The law requir ite has been si age 2 should	Completed								opsy	24b. Were aut prior to co	topsy findings completion of c	available cause of
<u>e</u>	t: The icate h								12 Yes	formed? 2 \( \text{No} \)	death? 1 X Yes	2 🗆 No	
V.	sician s certif	o Be	25. Was case referred to medical examiner? 1 ▼ Yes 2 No	Hospital	Inpatient 2	☐ER/Outpatie	nt 3□ DOA Ot	hor	ath <i>(Check only</i> Home 5 - Res		ther (Spec	eity) AT S	CENE
of	ng Phy ter this	T :uc	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time of			28d. Describe			,,,	
Division of Vital Records.	tendir leath. tor: Al	catle	1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	gation	no of Injury At 1	home form of	M 1 [	Yes 2 □No	29f Location	(Street and )	Number or Rui	ra/ Boute Nur	nhar
Divi	after of Direct of in by	Certification;	4 ☐ Homicide determ	ined 209. Fia	ding, etc. (Spec	ify)	reet, factory, office			own, State)	varigor or via	ar riodio rion	DOT,
8	ospite hours uneral		29a. Certifier 1 Certifyir (Check only 1 Medical	ng Physician: To the Examiner: On the	he best of my kn	owledge, dea	th occurred at the ti	ime, date and place	e, and due to the	e cause(s) ar	nd manner as lace, and due	stated.	s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29b. Signature and title of certifie	and ma	inner stated.			se number			signed (Month		-
	5 X X Z			Mal	Ala		0.0	C.M.E		DEC	. 27,	2004	
			30. Name and address of person	who completed ca			Print) NN STREET	ר פאוידר	IODE MAD	VI AND	21201		
	Sta	ate.	31. Date filed (Month, Day, Year)		Registrar's Sign	nature 🖟			OKE, TAK	THAMD	21201		
	Regist		DEC 30	2004	Seneva	P	Space	V					

State of Maryland / Department of Health and Mental Hygien 42090 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician SALAMONE** 15, 2004 MILDRED December M. 1:24 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

R Q Yrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Country)
Mar. 15,1916 Connecticut Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🕅 F 042-09-5745 88 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importment: If term 271s marked other than "natural" contractions any injury or other trainment 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No Md. Montgomery Gaithersburg Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Odenhal Ave. #307 20877 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2X No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louis Monica Catherine Malcarne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18615 Carriage Walk Circle Gaithersburg, Md. 20879 Gloria Brewer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Dec. 21, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Sebastian Cem. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 2004 Middletown, Ct. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home weter 23a. Part. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10 east Deer Park Dr. Gaithersburg, Md. 20877 Approximate Interval Between Onset and Death gastrointestinal Immediate Cause (Final hemorrhage **Physician** rours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ischemic culitis hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 22 No 1□ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 22 NO 2 1 Tes 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1/2 Netural 5 Pending investigation 1 Tes 2 No death. 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 15,2004 Mestres DS9738 licia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alicia T. Mistry M.D. 9901 Medical Center Dr. Rockville, Md. 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks Registrar DEC 16 2004

	1 _ State	State of Ma		epartment of Sertificate of	Health and N		C O O 4	4209
	Registrar  1. Decedent's Name (First, Middle, L	acti		erincate o	Dealli	Re 2. Date of Death	g. No.	3. Time of De
n						_ Month	Day Year	
al	Edward Francis			45.00 7		Decemb		
er	4a. Facility Name (If not institution, g			4b. City, Town	, or Location of Death		4c. County of Dea	
	Washington Count			Hagers			Washingt	
	103-20-1203	Sex 7. Age	e (In yrs. last birthd 76 Yrs	Months Day		8. Date of Birth (Month, Day, Jan. 21, 1	9 Bir 928 New	thplace (State or Fountry) York
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City
7	Maryland Frede	rick		lerick				1 □ Yes 2
Director			1160					<u> </u>
늗	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	ountry?
<u>a</u>	2520 Waterside D	rive		2170	02		U.S.A.	
Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decedent o	f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
Ŧ	1 Never Married 20 Married	1 ☐ Yes 2x51					Black, Whit	
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2KTXN	lo Specify:		Specify:	white
Completed	15. Decedent's (Specify only highest of	Education	16a. D	ecedent's Usual Occ	supation ne during most of work	ina 1	6b. Kind of Business	/Industry
pe	Elementary/Secondary (0-12)	College (1-4or 5		e. DO NOT use reti	red)	mig		
E O	2.511011017,0000110017 (0 12)	5+		1omat			U.S. Gove:	rnment
ø	17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
To B	Thomas Shedlick	k			Genevie	eve Broug	hton	
Ĕ	19a. Informant's Name/Relationship	(Type Print)	19h M	ailing Address (Stre	et and Number or Rur			Zin Codel
	Elizabeth Shedlio			_	de Drive,			
	20a. Method of Disposition			sposition (Name of			Oc. Location - City or	
	1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	cemetery,	crematory or other p	lace)		oo. Location - City or	TOWN, SIBIU
	`4 □Donation 5 □ Other (Spec	cify)		on Nation			rlington,	
	21. Signature of Funeral Service Lic	ensee	1	22. Name and Add	fress of Facility Sta	uffer Fu	neral Home	9
	Sharon (An	ulle tot	ene)		sumtown Pi			
	23a. Part1. Enter the disease, or co	mplications that caused	the death. Do not					Approximate
	shock, or heart failure. List on Immediate Cause (Final	y one cause on each lin	ie.	1	1			Onset and De
	disease or condition resulting in death)	a. Inv	c, cerebrul	Men	or high			240
		Due to (or as	a consequence of):					•
_	Sequentially list conditions,	b						
aminer	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	that initiated events	с.						
Ě	resulting in death) Last	Due to (or as	a consequence of):					
		d						
	2							
		23c. If yes, outcome		- 53-			23d. Date of de	livery
	IF FEMALE: 23b. Was decedent pregnant		2 Fetal death	3 Ectopic pregnar	ncy		Month	Day Yea
	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	time of death	5 Other (specify)				
	23b. Was decedent pregnant		time of death	5 ☐ Other (specify)				
Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			given in Part I	23e. Did toba	acco use contribute to	the cause of dea
by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			given in Part I.		acco use contribute to	
by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			given in Part I.		acco use contribute to	
by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			given in Part I.	1 ☐ Yes 24a. Was an	2 No 3 Pr	obably 4 Unk
by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			given in Part I.	1 ☐ Yes 24a. Was an autopsy perform	24b. Were au prior to death?	robably 4 Unk
e Completed by Physician/Medical E	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown				1 ☐ Yes 24a. Was an autopsy	24b. Were at prior to death?	

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

F

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Phy /M Exa

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

State

Medical Certification:

1 Natural

29a. Certifier (Check only one)

2 Accident 3 Suicide
4 Homicide

29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

Omalle 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

DEC 2 0 2004 >

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			State of Maryland / Department /	artment of Health and Mental I	Hygiene 2004	42092
			Registrar Amended #26perMD FCHD, KS Cel	TITICATE OF DEATH	Reg. No.	3. Time of Death
	Physicia	an	Luther Milton Smith, Jr.	Month Dec	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
	ZX		3405 Farthing Drive	Wheaton	Montgome	rv
	Funeral		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> ) 5.70 27. 7.5 1	If Under 1 Year   If Under 24 Hrs. 8. Date of Months   Days   Hours   Min.   Month	f Birth 9. Birth , Day, Year) C	thplece (State or Foreign
	Director		579-34-4549	Nov.	2, 1929 Son	ıth Carolina
	yland low		10a. State 10b. County 10c. City, Town or Lo	ecation		10d. Inside City Limits
	e-1sh	ctor	Maryland Montgomery Wheaton			1 ☐ Yes 2 XNo
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
	s 23a	rai	3405 Farthing DRive	20906	United Sta	
	ter de Item iner n	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 12 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc		
036	al', or	by I	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates: Korean	1 ☐ Yes 2 🗓 No Specify:	Specify:	White
2-0	72 ho	Completed by Funeral Director	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business	/Industry
121	vithin ne. hen "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	Safeway N	feat Dept.
7 0	filed within 72 hours after death with the Maryland Hygione. Ither then "natural", or Items 23e or 28e-f show ant, the Macifcal Examirer must be notified at	CO	10 Mana 17. Father's Name (First, Middle, Last)	.ger 18. Mother's Name (First, Mi	ddle, Maiden Surname)	
an	id be ental ked o	To Be	Luther M. Smith	Mary M. Keem	an	
Maryland 21215-0036	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rural Route N		Zip Code)
Σ	and 2 salth a n 27 l			N. Reyburn Court, Mt.		· <del>-</del>
ore	ges 1 t of He If iten or oth	( !	20a. Method of Disposition 1 ဩBurial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Dispo	sition (Name of Date matory or other place)	20c. Location - City or	
Baltimore,	t. Pag tmen tant: ijury		`4 □Donation 5 □Oyler (Specify) Parklawn		4 Rockville,	Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene I mortant: or thems 23a or 28a-1 show Important: If item 27 Is marked other then "natural", or thems 23a or 28a-1 show any injury or other treumatic event, the Moulcal Examiner must be notified at once.			2 Name and Address of Facility lin L. Molesworth PA, 6401 Ridge Road, Damas		20872
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition a. Pancreati	c Cancer		Onset and Death  3 weeks
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	uted d ansit	Examine	cause. Enter Underlying Cause (Diseese or injury that initiated events c.			
0	e exection and interpretable in an analysis in analysis in an lysis in analysis i	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medicai	d			
9	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livon
Вох	atten after u	cian	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	Month	Day Year
O.	that the de ed by the detached	hysi	9 Unknown 9 Unknown			
S,		by P	Part II. Other significant conditions contributing to death but not resulting in the u	3	Did tobacco use contribute t	
ord	w requires been sign should be				1 ☐ Yes 2 ☑ No 3 ☐ P	robably 4 Unknown
Vital Records,	aw as b	Completed			Was an autopsy prior to death?	utopsy findings available completion of cause of
alF				1 □ Y	es 2 No 1 Yes	2 □ No
<u>Sit</u>		o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No  Hospital: 1 □ Inpatient 2 ☑ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	26. Place of Death (Check of the charter)  Other: 4 \sum Nursing Home 5	nly one) Residence 6 □Other (Spe	ncifu)
ol	g Physer this leral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		ribe how injury occurred	uny)
Sior	Attending F r death. ector: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No		
Division	in Site	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Locati City o	on (Street and Number or R r Town, State)	ural Route Number,
	pitel ours erel filled	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place, and due to	the cause(s) and manner a	s stated.
	d the	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To the within 2. To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon-	th, Day, Year)
•			I sha Ud / L	M 36975	December 1	6, 2004
1	O.		30. Name and address of person who completed cause of death (Item 23a) (Type,			20010
	Sta	ite	T. David Shocket, M.D. 106 Irving  31. Date filed (Month, Day, Year)  DEC 2 0 2004	Street, N.W Suite	ردی, Washingt	on, D.C.
	Registi		DEC 2 0 2004	And the second		

C	4-021/											
E	K.S		Please Ty	ype or Print in E	Black Ind	delible Inl	k. Ensu	re All Copie	s Are	Legible.		
G	OODWIN	SC	HLOSSBERG	State of Marylan	d / Depa	rtment of	Health a	nd Mental H	ygiene			
		•	1- State Unpend Item 23	3a,pt.II,27 p	er me	ini39te o	Death <sup>t</sup>	as	Reg. No.	1000	1.20	03
			Decedent's Name (First, Middle, Last)					2. Date of D	eath		3. Time of E	Death
	Physicia		Goodwin Sc	hlossberg				DEC.	$21^{Day}$	2004 Year	0043	ΔΜ
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town,		f Death		County of Death		Δ
8	LAUIIIII	٠.	PRINCE GEORGES H	OSPITAL CENT	ER	CHEVE	ERLY		I	PRINCE (	SEORGES	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Day		24 Hrs. 8. Date of B	irth Day, Year)	9. Birth	place (State or untry)	Foreign
	Director		152-40-6564	<sup>M 2□F</sup> 53	Yrs.	Moritins Day	S FIOUIS	January			York	
	p		Usual Residence of Decedent	100 00	y, Town or Lo						404 1	A 1 - 14
	shov	_	10a. State 10b. County		y, rown or Lo	ation					10d. Inside City 1 ☐ Yes	
	89-f	cto	Maryland   Prince Ge	orges Bo	wie				T		24	
	vith th	Director	10e. Street and Number			10f. Zip Code				zen of What Cor	untry?	
	s 23e	Funeral	15011 Nashua Lane	0 W - D	0 100	20716		-0.40		S. A.	iona Indian	
	er de	Ę.	11. Marital Status 1 Never Married 2 Married 1	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No</li> </ol>	5. 13. V	Yes, specify Cu	iban, Mexican,	in? (Specify Yes or N , Puerto Rican, etc.)	10-	Black, White		
36	hours after death with the Maryland tural', or Items 23e or 28e-f show at Examiliar inust be invitiled at	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 🏖 N	o Specify:			Specify: W	nite	
21215-0036	thou stura		15. Decedent's Educ	ation	16a. Deced	ent's Usual Occ	upation		16b. Kii	nd of Business/I	ndustry	
15	n "nat	piet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give :	kind of work don OO NOT use reti	ne during most red)	of working				
212	d within giene. rr than "	Completed	Liententary/Secondary (0-12)	5+		Attorney	<b>y</b>			Law		
D	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or Items 23e or 28e-f show event, the Medical Examination must be inciliated at	Be C	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (First, Midd	le, Maiden	Sumame)		
<u> a</u>	should be and Mental s marked o umatic eve	To	Alvin Schlossberg				F1o	ra Wilner				
Maryland	sho		19a. Informant's Name/Relationship (Type	•	19b. Mailin	g Address (Stre	et and Number	r or Rural Route Num	ber, City o	r Town, State, Z	ip Code)	
Σ	and and alth		Cynthia L. Schloss		_		a Lane,	Bowie, Ma				
ore	Care and		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re	_	lace of Dispo: emetery, cren	sition (Name of natory or other p	lace)	Date	20c. Lo	cation - City or	Town, State	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic events.		'4 ☐Donation 5 ☐ Other (Specify)		dean M	em. Gard	dens 12	/24/2004	01n	ey, Mary	/land	
alt	epart epart poort ny inj		21. Signature of Funeral Service License		22 D:	Name and Add	tress of Facility	erg Memor	ial Cl	hapels.	Inc.	
_	90 Z 2 0		Conald (, )	Hottlemy	2 1	170 Rock	kville	erg Memor: Pike, Rocl	cville	e, Mary		0852
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the feat e cause on each line	h. Do not ente	er the mode of d	ying, such as o	cardiac or respiratory	arrest,		Approximate Interval Betwoonset and De	reen
	Pnysician	e i	Immediate Cause (Final disease or condition resulting in death)	Hypertensive	Athero	sclerot	ic Card	liovascu1a	r Dis	ease	0.100, 4.10 0	04
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							
Ŋ.		_	Sequentially list conditions, b.	Due to (or as a conse)	uence offi-						- N	-
	ed sit	iner	days leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to gar as a conseq	dornos ogy							
	xecuted and al-transi	xamin	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
68760,	0	a E										
387	death certificate be a attending physicia d for use as the bur	Physician/Medical	0.									
Box (	certii nding use a	N/W	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna					2	23d. Date of deli	verv	
ğ	death cert attendin	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnar Other (specify)				Month		ear
0	at the de by the a tached	hysi	9 Unknown	9□Unknown								
0	de ed	by P	Part II. Other significent conditions con-	tributing to death but not res	ulting in the ur	derlying cause	given in Part I.	23e. Dio	tobacco u	ise contribute to	the cause of de	ath?
Records,	w requires been sign should be		Diabetes Mellitus					1	]Yes 2[	□ No 3 □ Pro	obably 4 🗆 Ur	nknown
000	s bee	olet						24a. We		24b. Were au	topsy findings av	vailable
æ	The lav	Completed						per 1 Yes	opsy formed? 2 Z No	death?	ompletion of cat 2□ No	USB 01
Vital		a)	25. Was case referred to medical				26. Place	of Death (Check only		1		
<u>&gt;</u>	ysic S ce	To B	examiner? 1 X Yes 2 □ No	ospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA	Other: 4 Nur	rsing Home 5 🗆 Re	sidence (	6 ☐Other (Spec	ify)	
J Of	ding Phy h. After thi funeral (		27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In	jury at vork?	28d. Describ	how injur	y occurred		
Ö	tendir Jeath. tor: Af the fur	atic	2 Accident investigation				Yes 2 N	No				
Division	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, offic	e	28f. Location City or T	(Street and	d Number or Ru )	ral Route Numb	er,
Q	ital o irs aff ral D	Se										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the fune.	edical	(Check only 27 Medical Exemin	icien: To the best of my kno ier: On the basis of examina	wledge, death	occurred at the restigation, in my	time, date and y opinion, deat	d place, and due to the hoccurred at the time	e cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)	
	the l	Med	29b. Signature and title of certifier	and manner stated.			ense number			te signed (Month		
	To To	-	Zoli illa	1 de -			.C.M.E		DEC	_		
•					- 00-1 =				טנוכ	- 21,	<u></u>	
			30. Name and address of person who con	mpleted cause of death (Iter	n 23a) (Type, .11 PFN	rint) N STRFF	Т Вліт	IMORE.MAR	OT ABTE	2.		
	₂ Sta	to		32. Begistrar's Signa	ature			THOKE MAK	rland)	<del>-</del> 41211		
	Registr		31. Date filed (Month, Day, Year) DEC 28 200	32. Begistrar's Signa	19	Spark	21					
1						1 1						

	•	1 - For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment rtificate	of Health of Death	and Mei h		iene) g. No.	004	42094
		1. Decedent's Name (First, Middle, I	Last)					2.	Date of Deat Month	h Day	Year	3. Time of Death
Physici /Medio		Jean A	١.	St	ider			De	ecembe			2:48 a <sup>M</sup>
Examir		4a. Facility Name (If not institution, g	ive street and num			4b. City, 7	Town, or Locatio		Jecimo C.	4c. Coi	unty of Death	n
		Laurel Regiona					ırel			Pri	nce Ge	orge's
Funeral			.Sex 1□M 2 <b>x</b> F	7. Age (In yrs.	last birthday) Yrs.	Months	1 Year If Und Days Hours		Date of Birth (Month, Day,		9. Birth Cou	nplace (State or Foreign untry)
Director		Usual Residence of Decedent	7A-2A	72	Yrs.			Ma	irch 3,	193		h Carolina
and		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
Mary # 8 h	jo	Maryland Montgo	mo *rr	Ca	1	·						1 Yes XXNo
288 100 in	Director	10e. Street and Number	шету	1 91	lver S	10f. Zip			1	0g. Citizen	of What Cou	untry?
3a ol	Ö	12513 Galway Dri	ve				20904				USA	
vors after death with the Marylan burs after death with the Marylan Este illust route be ricilified at	Funeral	11. Marital Status		dent Ever in U.	.S. 13.	Was Deced	ent of Hispanic C ify Cuban, Mexic		y Yes or No-		Race - Amer	
or its		1 Never Married 2 Married		2 ₩ No		1 ☐ Yes 2			ari, etc.)		Black, White	
72 hours	d by	3 ₩ Widowed 4 Divorced	Year or Da	ites:		10103 2	- Open	.,.		Spi	ecify: Wh:	ite
72 hc	Completed	15. Decedent's (Specify only highest)			(Give	kind of won	Occupation k done during m	ost of working		16b. Kind o	of Business/I	ndustry
Mithin Mithin	dm	Elementary/Secondary (0-12)	College (1-	-4or 5+)		DO NOT us	,					
ified within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23s or 28s-f show ont, the Macifed Extended the notified at		12 17. Father's Name (First, Middle, La	st)		E	Iomema		ther's Name (F	irst. Middle. M	Aaiden Sur	Own I	Home
yiding 212 buld be filed with Mental Hygiene. arked other than	) Be	Robert Evans	,								,	
Lally latter A. L.C. 2 should be filed within and Mental Hygiene. is marked other than reumatic event, the M.	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street and Nurr		andler		wn, State, Z	ip Code)
and 2 sealth ar n 27 is ner trau		Katharine L. Sni	der / Dau	ughter		-	od Road					777
- I D T T T T T T T T T T T T T T T T T T		20a. Method of Disposition		20b. P	Place of Dispo emetery, crea	sition (Nam	e of	Date			ion - City or 1	
permit. Pages Department of I Important: If it any injury or o		1 ☐ Burial 2☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe	Removal from S	State				19/14/	2004	D		
permit. I Departm Importa any inju		21. Signature of Funeral Service Lie			22	2. Name and	d Address of Fac	Hines	Rinal	brent Ji r.,	wood,	Maryland
Deparii Deparii Impol		1 suns t	Nee	don	1	1800	New Ham	shire	Ave si	ur ru Iver	Spring	3, MD 20904
\$		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	emplications that can't one cause on ea	aused the deat	h. Do not en	ter the mode	of dying, such	as cardiac or re	espiratory arre	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		tatic C	arcino	ma of	Liver					Onset and Death
/Medical		resulting in death)	a	or as a conseq								
Examiner		Sequentially list conditions				inoma	of Lung	3				
₽ ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq	,							
ecute and trans	Examin	that initiated events resulting in death) Last		or as a conseq		bstru	ctive Lu	ing Dis	ease			
cate be executed physicien and the burial-transit				Dyspla:								
I necolus, F.O. BOX 00/00,  The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	edicai		d. 11) C10	рубріа	51a							11-2
that the death certificated by the attending p	/Me	IF FEMALE:	23c. If yes, outo	come of pregna	ancy					234	. Date of delin	werv.
Buth cert attendin for use	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bi	irth 2 ☐ Feta ant at time of d	Ideath 3	☐Ectopic pre☐ Other (spe				250.	Month	Day Year
the d	Physician/M	1 □ Yes 2 2 No 9 □ Unknown	9□ Unkno				,,					
that ed by deta		Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	inderlying ca	ause given in Pai	rt I.	23e. Did tob	acco use	contribute to	the cause of death?
w requires to been signed should be	d by	Renal insuffi	ciency						1 <b>₹</b> Y€	s 2 N	o 3 Pro	obably 4 Unknown
w requires that be been signed to should be detailed.	Completed	Azutemia							24a. Was a	n 24	4b. Were aut	topsy findings available
Or VICAL DEC Physicien: The lav this certificate has al director, page 2	mo	_							autops	ned?	death?	ompletion of cause of
	0	Anemia 25. Was case referred to medical					26. Pla	ice of Death (C	1 ☐ Yes 2		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2   100
ysicii s cer direct	0 8	examiner? 1 ☐ Yes 2 ➡ No	Hospital: 1 1	npatient 2 🗆	ER/Outpatie	nt 3 DO.	Othor	Nursing Home			Other (Spec	ifv)
_ m & w	n: T	27. Manner of Death	28a. Date o		28b. Time o		8c. Injury at Work?		I. Describe ho			,,
Attending Is death. ector: Atter by the funer	atio	1 ♣Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	,,, ,,,	11,07	М	1 ☐ Yes 2	□No				
r Atte	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place	of Injury - At he	ome, farm, st	reet, factory,	, office	28f	Location (St. City or Town		umber or Rui	ral Route Number,
ital o rs aft ral Di	Cer											
Hosp 4 hou Fune ely fil	edical	(Check only 2 Medical Ex	Physician: To the caminer: On the ba	asis of examina	wledge, deat	h occurred a	at the time, date in my opinion, d	and place, and eath occurred	due to the ca	use(s) and	d manner as	stated. to the cause(s)
To the Hospital or Attending Phywitin 24 hours after death. To the Funeral Director: Atter the completely filled in by the funeral	Med	one)	and mann	ner stated.			. License numbe				gned (Month	
2 1 0 0		29b. Signature and title of certifier	das	3. AA	1)	250.	21	200				
12							7 3-1-				100	2004
		30. Name and address of person w										
C+	ate	Shrinivas R. Ud 31. Date filed (Month, Day, Year)	1 <b>ap1,M.D.</b> 32. <b>₽</b>	/245E egistrar's Signa	Hanov	ver Pa	rkway G	reenbel	t, Mar	yland	20	770
∠ Regist		DEC 14 2		que	B	popo	ch					

			For State Registrar	State	of Ma	ryland / De	oartmen e <i>rtificat</i>					giene Reg. No 0	14	420	95
	Physici	an	1. Decedent's Name (First, Middle Martin	, Last)	C +	auss					2. Date of Dea	Day	Year	3. Time of	
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu		auss	4b. City,	Town, or	Location (	of Death	Decemb	4c. County 6		12:1	/ a ™
	LAGIIIII	CI	Suburban Hospit	al				ethes	sda			Mon	tgom	ery	
	Funeral Director		5. Social Security Number 081-24-2816	6. Sex 1 ☑ M 2 ☐ F	7. Age 81	(In yrs. last birthda Yrs.	y) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da July 1	y, Year) 4, 1923	Cour	lace (State o try) any	or Foreign
	land bw		Usual Residence of Decedent  10a. State 10b. County			10c. City, Town or	Location						1	0d. Inside C	ity Limits
	Mary B-f sh	tor	Maryland Montg	omery		Bethe	sda							¹ 🛱 Yes	2 □ No
	or 28	Director	10e. Street and Number	1			10f. Zip					10g. Citizen of W		,	
	eath v	erai	6005 Durbin Roa	12. Was Dec	edent F	ver in U.S. 1	Was Dece	2081		igin? (Spe	cify Yes or No.	United		es an Indian,	
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or iteme 23e or 28e-f show event, the Medical Eraminar must be notified at	by Funerai	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? 2⊠N ive	0	If Yes, spe		n, Mexicar Specify:		cify Yes or No- Rican, etc.)	Black Specify:	, White,		
21215-0036	2 hour	ted t	15. Decedent	's Education	-	16a. De	edent's Usu	al Occupa	ation			16b. Kind of Bus			
215	within 7 ene. than "n he Wedi	Completed	(Specify only highes Elementary/Secondary (0-12)	College		+)	e kind of wo DO NOT u	se retired,	)	t of workir					
121	e filed withing Hygiene. other than vent, the M		17. Father's Name (First, Middle.	l ast)		Busi	ness (	)wner		ar's Name		Photogra Maiden Sumame		Electi	ronics
Maryland	should be I ind Mental I marked of umatic eve	To Be		trauss						essie		Grue		in	
Mar	12 sho h and 7 ie m traum		19a. Informant's Name/Relations! Carolyn K. Stra		Fο						Route Numbe nesda,	er, City or Town, S MD 2081	_	Code)	
ē,	thealt		20a. Method of Disposition	uss wi		20b. Place of Dis			-		ate .	20c. Location - (		wn, State	
mo	Pages of mr. File		1 ☑ Burial 2☐ Gremation  4☐ Donation 5☐ Other (S		State					2/12	/2004	Adelphi	, Mai	yland	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any Injury or other traumatic evones.		21. Signature of Fur ral Service	License	m		22. Name ar Danzar 1170 I	d Addres	s of Facility Gold 7ille	berg Pike	Memori , Rock	al Chape ville, M	1s, D 2	Inc. 0852	
			23a. Part 1 Enter the disease, or shock, or heart failure. Lis	only one cause on	each lin	θ.	enter the mod	le of dying	g, such as	cardiac o	r respiratory ar	rrest,		Approximat Interval Bet	ween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Art	eri	o Sclev	oti'C	C	ardi	ova	scular	Diseus	2	Onset and	Death
	Examiner		SERVICE CONT. TO PRODUCT TO THE	Due to	. 1	a consequence of):		mo	111	tuc					
		ner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to		a consequence of):	1154								
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	U.		consequence of):	14	pert	ten s	SiUr	\				
8760,	rate be executed obysician and the burial-transit	ical E	,		1	onar	F	ib	ro:	sis					
9	tificate ig phys as the	ledic		0.		1					-				-
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		birth	2 ☐ Fetal death	B∐Ect <i>o</i> pic p					23d. Date		-	Year
P.O. I	by the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unkr		time of death	5 ☐ Other (sµ	ecify)							
	gned be de	by	Part II. Other significant condition	ons contributing to	death bu	ut not resulting in the	underlying o	ause give	en in Part I			obacco use contri			
Records,	w requir been si should	eted				·· <del>·</del>					24a. Was	- 7	3 Prob	osy findings	Jnknown
Rec	The lay	Completed							<del></del>		autop perfo	psy pr rm <del>y</del> d? de	ior to coreath?	npletion of c	ause of
Vital		BeC	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		Yes	2   140	
of V	Physiclan: this certific ral director,	To	examiner? 1 X Yes 2 □ No		Inpatie	and the same of th			4 111			dence 6 □Othe		')	
	ding h. Atter tune	tion:	27. Manner of Death  1 Natural 5 □ Pendin  2 □ Accident investic	9	of Injur	y 28b. Time Yea <i>r)</i> Injur		28c. Injury Work	≀at <br Yes 2. □		8d. Describe h	now injury occurre	d		
Division	Attending redeath. ector: Atterby the funer	Certification:	2 Accident Investig	not be 28e. Plac		iry - At home, farm,					8f. Location (S City or Tox	Street and Numbe	r or Rura	l Route Num	ıber,
Ö	itel or rs afte rel Din led in l					:. (Specify)									
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To th Examiner: On the I and mai	basis of	of my kn <i>o</i> wledge, de examination and/or ted.	ath occurred investigation	at the tim , in my of	ne, date an pînion, dea	id place, a ith occurre	nd due to the o	cause(s) and man date and place, ar	ner as st nd due to	ated. the cause(s	)
	To t Withi To tl	Ž	29b. Signature and title of certified	-10	P	100	29	License	number	5		29d. Date signed		Day, Year)	4
•	10		30. Name and address of person	who completed car	USB of d	enkerty M	e, Print) F	rede	U (	W:11	iam Rar	dolph. M	1.D.~	,200	l
-			8600 old	George	fair	n RL	o, rimij <b>F</b>	Be	Thes	Ja	M	ndolph, A	20	315	5
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 14	2004	egistra	tr's Signature	Sp	nks	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrameno#1perMD12/28/04, PMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death SHUFORD SCHUHMANN Month **Physician** Shuford Schuhman  $A^{\mathsf{M}}$ 11, December 2004 3:09 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 25, 1 Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F Min. Yrs Director 578-58-7798 88 Ĭ916 Texas Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location ir than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 🏋 No MD Montgomery Potomac Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9210 Kentsdale Drive 20854 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. It is marked other than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: þ Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist 4 Federal Government other traumatic event, 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Reinhardt Schuhmann Alice Shuford 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Schumann / Daughter 6804 Tulip Hill Terrace, Bethesda, MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State December 13,2004 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) injury or permit. Page Department of Important: If any injury or Alexandria, Virginia Metropolitan Crematory 21. Signature of Funeral Servi Livens 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer IRAC Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Vascular Accident /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to inhimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examine Hospital or Attanding Physician: The law requires that the death cartificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one) Other: 0 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗌 Homicide within 24 hours a To tha Funaral C 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 2 29d, Date signed (Month, Dav. Year) 00567 G

State

Registrar

1500 Forest Glen Road, Silver Spring, MD 20910-1484

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Luis Gonzalez, M.D.,

DEC 15 2004

31. Date filed (Month, Day, Year)

		For State Registrar	State of I	Maryland / D	epar <i>Certi</i>	tment of H ificate of	lealth and Death		giene Reg. No.	004	42097
		Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
Physici /Medic		Ruth Corrinne Van	Steenbo	erg				Decemb			3:30 P M
Examir		4a. Facility Name (If not institution, give s	treet and number	er)		4b. Cily, Town, o	r Location of Deat	th	4c. Co	ounty of Death	
		2510 Briggs Chane				Silver	Spring If Under 24 Hrs			tgomery	
Funeral		5. Social Security Number 6. Sex	M 2∏F	Age (In yrs. last birth 84 Y		Months Days	Hours Min	. (Month, Da			lace (State or Foreign stry)
Director		295-03-6465 Usual Residence of Decedent		04				02/20/	1920	New	iork
yland		10a. State 10b. County		10c. City, Town	or Loca	ation				1	0d. Inside City Limits
Mar illed	ctor	MD Montgome	ry	Silver	Spr	ing					1 ☐ Yes 2X No
if the or 28	)ire	10e. Street and Number				10f. Zip Code			_	n of What Cour	itry?
ath w	rai	2510 Briggs Chane			1	20905		2 1/ 1/		.S.A.	an Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any july or other traumatic event, the Medical Exarch with minist be notified at once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ☐ Yes 2	es?	13. W	as Decedent of h Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	specify Yes or No rto Rican, etc.)	)- 14	Black, White,	etc.
urs af	by	3	If Yes, Give Year or Date		10	⊒Yes 2. No	Specify:		Si	pecify: Wh	ite
72 ho	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	16 <i>a</i> .	(Give ki	nt's Usual Occup ind of work done	during most of wo	orking	16b. Kind	of Business/In	dustry
ithin ithin	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. DO	O NOT use retire	d)			**	
led w tygier ther th	ပ္ပ	12 17. Father's Name (First, Middle, Last)		HC	omem	aker	18 Mother's Na	me (First, Middle	_	Home	
id be fill ental Hy ked oth	Be	Joseph J. O'Brien						et A. Bu		omano,	
thouse of Me mark matic	10	19a. Informant's Name/Relationship (Ty	pe. Print)	19b.	. Mailing	Address (Street	and Number or R			Town, State, Zip	Code)
NCAI		Corrinne Van Steen		aughter 25	510	Briggs	Chaney R	d, Silve	r Spr	ing, MD	20905
S 1 ac f Hea f Hea othe		20a. Method of Disposition		20b. Place of	Disposi			Date		ation - City or To	
Page Training Trainin		1 ☐ Burial 2 XX Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	are i ere		-		18/2004	Bren	twood,	Maryland
Default: Pages Department of I mportant: If It iny injury or o		21. Signature of Furlary Service Licens	90 /	1		Name and Addre		Simple			
0 898 <b>9</b>		Janly Lea	Werley	M						, Maryl	and 20852
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that cau ne cause on eac	set the death. Do n h ine.	not enter	r the mode of dyi	ng, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_Basal	Cell Card	cino	ma					Years
/Medical Examiner		resulting in death)	Due to (or	as a consequence of	of):						
	Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of	of):						<del></del>
uted d ansit	Examine	cause. Enter Underlying Cause (Disease or mijuly) that initiated events									
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or	as a consequence of	of):						
or ou	dicai		d								
artifica ing pt	Med	IF FEMALE:						-			
that the death certificated by the attending problem of the attending problem of the tree as	Physician/Me	23b. Was decedent pregnant in the past 12 pronths?	1 Live birt	me of pregnancy  h 2 Fetal death  at time of death		Ectopic pregnand Other (specify) _	у		23	Id. Date of delive Month	ory Day Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		3 📑	Other (specify) _					
that the the the the the the the the the th	y Ph	Part II. Other significant conditions co	ntributing to dea	th but not resulting in	n the und	derlying cause gr	ven in Part I.	23e. Did	tobacco use	e contribute to t	ne cause of death?
cords, w requires t been signe should be	d by							1 🗆	Yes 2	No 3□Prol	pably 4 Unknown
HECOLUS, he law requires t has been signe	Completed							24a. Was			psy findings available mpletion of cause of
age he	E O							perf	ormed? No	death?	2 No
VICAL ilcian: T certificat rector, p	Be C	25. Was case referred to medical examiner?						eath (Check only	one)		
- × 50 P	일	1 ☐ Yes 2 No	Hospital: 1 ☐ Ing			3 DOA		Home 51 es			(y)
ing P	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of (Month,		Time of Injury	28c. Inju Wo M 1 T	iryat irk? ]Yes 2 □ No	28d. Describe	now injury	occurred	
ISIO ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e Place o	f Injury - At home, fa	arm. stre		165 2 100	28f. Location	Street and	Number or Rur	al Route Number,
DIVISION I or Attending after death. Director: Afte	Certification:	4 ☐ Homicide determined	building	, etc. (Specify)	,	,		City or To	wn, State)		
UIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 X Certifying Phy	sician: To the b	est of my knowledge	e, death	occurred at the t	ime, date and place	ce, and due to the	cause(s) a	and manner as s	tated.
n 24 i n 24 i he Fu pletel	edical	(Check only 2 Medical Exam	and manne	is of examination and stated.	navor inv			Surred at the time			
To t To t	Σ	29b. Signature and title of certifier	1-				se number			signed (Month,	)
12		p Burelle					5014		DEW	ハクレレ	13/2004
12		30. Name and address of person who c		of death (Item 23a) (	(Type, F	Print)	\_ i  -	21127	D 2	2707	
	tate	31. Date filed (Month, Day, Year)	32. R	gistrar's Signature	E	mon 1	t it	0.000		, ,	
Regis		DEC 15 20	04	merca /		spork	n)				

			1 - State Amend Items Registrar	State of Ma 25,26,27,2	aryland <b>9a p</b> e	d/Depa er <b>Dr</b> en	artment	of H	ealth a	and Men 005dhb	ital Hyg	iene	$\Omega$ L	L2098
	Physici /Medic		1. Decedent's Name (First, Middle, L Donald S		+					2. [	Date of Dea Month	Day	Year	3. Time of Death 3 15 A M
>	Examin Funeral Director		4a. Facility Name (If not institution, g University of 1 5. Social Security Number 6. 233-64-5189	naryland	Hos (In yrs. la	pital ad birthday) Yrs.	Ba If Under Months	Itiv	N O CO If Under Hours	24 Hrs. 8. 1	Date of Birth	4c. County		ace (State or Foreign
	D	tor	Usual Residence of Decedent  10a. State 10b. County  WV Hampsh	ire	,	, Town or Lo	cation						10	Od. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28e	ai Director	P. O. Box 12				10f. Zip				1	0g. Citizen of V	What Count	try?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-1 show other treumatic event, the Madical Examiner must be natified at	by Funeral	11. Marital Status  1  Never Married 2 Married 3  Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	Ever in U.S ło		Was Decedor of Yes, spec	ity Cubai	spanic Ori n, Mexicar Specify:	gin? (Specify n, Puerto Rica	Yes or No- n, etc.)		e-America ck, White, e /: Whi	etc.
21215-0036	sd within 72 h giene. er than "natu i the Medical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5	+)	16a. Deced (Give life. L	kind of won OO NDT us	k dorie d e retired)	luring mos )	t of working	(	16b. Kind of Bi General		ator Co.
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Ma	To Be (	17. Father's Name (First, Middle, La Santford G. Str						Vir	ginia (	Grace			
	1 and 2 sho Health and sem 27 is m		Doris (Hurly) S			P. 0.	Box	12,		ts, WV	25437			
Baltimore,	Page nent c ant: if ury or		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Signature of Linear Signature Lib	cify)	Ce		Fune	ral	Home	Dec. 2	20, 20	JU4	resap	
Ba	permit. Departimonto		23a. Part1. Enter the disease, or co	Wavn mplications that caused	the death							e 26757		Approximate
	Physician /Medical		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Sche	mic		trol	<e< td=""><td></td><td></td><td></td><td></td><td></td><td>Interval Between Onset and Death</td></e<>						Interval Between Onset and Death
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8760,	ficate be executed g physician and is the burial-transit	ical Examiner	that initiated events resulting in death) Last	c.  Due to (or as	a consequ	ence of):								
O. Box 68	ne death certi the attending hed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre					23d. Dai	te of deliver	y Day Year
rds, P.	quires that the signed by and be detacted	þ	Part II. Other significant conditions Hyperten	sion		ilting in the ur	nderlying ca	use give	n in Part I.			oacco use cont es 2 □ No	ribute to the	e cause of death?
Il Records,	The ate h page	Completed	Hyper cholo	estrolem	ia	*					24a. Was a autops perforr 1 □ Yes 2	ned?	Were autoportor to combeath?	sy findings available apletion of cause of
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ▼ No	Hospital:	nt 2□E	ER/Outpatien	t 3 🗆 DO.	A Othe		of Death (Ch		e) ence 6 □Oth	er (Specify	
on of	sing After	tion: T	27. Manner of Death  1 Natural 2 Accident  5 Pending investigat	28a. Date of Injui (Month, Day	у	28b. Time of Injury		Bc. Injury Work		28d.		ow injury occurr		
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not determine				eet, factory,	, office			Location (St City or Town	reet and Numb n, State)	er or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examinati									
)	To the within to the comp	Me	29b. Signature and title of certifier	Man		3	29c.	License	number +82	2	2	9d. Date signed	Month, D	
	10		30. Name and address of person of Michael Man	no completed cause of d nura 22 32. Registr	Sout	23a) (Туре,	Print)	5+	Bal	hmore	- M[	212	0/	
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 4 2005	Black 32. Registr	ar's Signat									

State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 8:50PM M December 23 2004 Roxanna Lumm Trump

4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1415 Lindsay Lane <u> Hagerstown</u> Washington County If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X) F 58 Yrs. March 31 1946 Maryland Director 215-44-9939 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23e or 28e-f show If e Madical Exercit er must be notified at 1XYes 2 No Funeral Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1415 Lindsay Lane 21742 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status d 2 should be filed within 72 hours after th and Mental Hygiene. 27 Is marked other then "natural", or ite treumetic event, if a Madical Examinat 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes . 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence 1.5 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Charles M. Limm Selma C. Chaffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 Is or other tre 1415 Tindsay Lane Hagerstown Maryland 21742

20b. Place of Disposition (Name of cametery, crematory or other place)

Hagerstown Maryland 21742

20c. Location - City or Town, State Richard F. Trump (husband) Baltimore, Pages 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. Rose Hill Cemetery Dec. 28, 04 Hagerstown Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 unda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer 4 yrs /Medical Due to (or as a consequence of) Examiner. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor No No 2 🗌 No 1 🗆 Yes 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours aft e Funerel Di letely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26806 December 24 2004 5H-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Ditto 747 Northern Ave. Hagerstown Maryland 21742 31. Date filed (Month Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 2004 9:00 P M 16, TAYLOR FRANCES MARIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro Prince Georges' 10135 Price Place #202 tf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/27/1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 TF 578-54-2210 Director Washington, DC 65 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show of 2 should be filled within 72 hours after death with the Maryla the and Manial Hygiene. 27 Is marked other than "naturel", or Itema 23a or 28a-1 show traumatic event, It a hedical Examination must be notified at 1 Tyes 2 □ No Director PG Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10135 Prince Place #202 20774 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Affied Forces: 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 58–60 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Legal Admissioner Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill iment of Health and Mental H lant: If item 27 Is marked other Be Theodore M. Bowlding Not Available 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel Taylor - Husband 10135 Prince Place #202; Upper Marlboro, MD 20774 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Pag Department Important: I any injury o MD Veteran Cemetery 12/22/2004 Cheltenham, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature 1 Funeral Service Licentee P.O. Box 416; Suitland, Maryland 20752 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final CARCINOMA. ASTATI **Physician** 74 MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Year Day 4☐Pregnant at time of death 5 Other (specify) o the detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1□ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2×500 70 1 Tyes in by the funeral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. after death € ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Dater signed (Month, Day, Year) 2 D-34525 30. Name and address of person who completed cause of death (Item 23a) Type. Printible Road #220; Bowie-Aug-20716 31. Date filed (Month, Day, Year) B2. Registrar's Signature State 2 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:45 P M 14, 2004 Dwight S. Thompson Dec. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia 10033 The Mending Wall If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Yrs. Director 044-24-6553 76 May 23. 1928 Connecticut Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r then "netural", or Itams 23a or 28e-f show the Medical Examinar coust be politified at 1 ☐ Yes 2 No Directo Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 10033 The Mending Wall 21044 deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1952-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 152 Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1973 1 ☐ Yes 2⁄2 No Specify: by Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within in Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Mealth once. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alta Sarah Downs Rov N. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21565 Oxford Drive Lexington Park, MD John Thompson / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem. Jan 19, 2005 Arlington, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family F.H., Inc. 21. Signature of Funeral Service Licenses M01044 4112 Old Columbia PK. Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) azhithmia Physician ardiac /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as t IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 3 Probably 4 Unknown 1 X Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 3□ DOA Certification: To this After th 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖎 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D31927 December 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Dr. Columbia 5450 Knoll mD Lai green

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Registrar

31. Date filed (Month, Day, Year)

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2004

32. Registrar's Signature

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			Decedent's Name (First, Middle, Last	)				2. Date of Dea	th ZUU	4	3. Time of Death
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	/Medic		4a. Facility Name (If not institution, give		1 uc.	4b. City, Town, or	Location of Deatl		4c. County of		3.23 P
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9	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2X Married	1 ☐ Yes 2 🌠 No If Yes, Give		1 ☐ Yes 2 💆 No		0 1 110411, 010.7	Specify:	, ***********	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):						
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Вох	ath c attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	fdeath 3□	Ectopic pregnancy			23d. Date Mon		ry Day Year
	the a	/slc	1 ☐ Yes 21 No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	eath 5L	Other (specify)					
P.0	The law requires that the death certifi vie has been signed by the attending is page 2 should be detached for use as		Part ff. Dther significant conditions co	entributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contril	bute to the	e cause of death?
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n C		lon	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		280. Describe no	ow injury occurre	a	
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	To the Hospital or Att within 24 hours atter of To the Funeral Direct completely tilled in by	Medical	29b. Signature and title of certified	and marinor stated.		29c. License	number	2	29d. Date signed	(Month, E	Day, Year)
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	Registr		DEC 2	32. Registral's Signa  0 2004	J. K.	parte					

			For State Registrar	State of Ma	aryland / [		artment of F		nd Ment	al Hygie	CUIIL	42103
			Decedent's Name (First, Midd	fle, Last)						ite of Death		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of			4c. County of Death	
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Maryland	d 2 s th an th an traul		Eva B. Tewel								on, Maryla	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28e-f show may july or opther traumatic event, it is Modical Executive in an item relified at ance.		21. Signature of Funeral Service		oudcui							
m	Depar Impor any ir		Donald (	! Xtottle	mues	- I	anzansky 170 Rocky	ville	Pike, I	Rockvi	Chapels, Lle, Maryl	and 20852
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused	the leath. Do	not ent	er the mode of dyir	ng, such as ca	ardiac or resp	iratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		reatic C							Onset and Death
	/Medical		resulting in death)		a consequence							
В	Examiner		Sequentially list conditions.		ration P		monia					
	sit a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as	a consequence	of):					- 4	
	and I-tran	хап	that initiated events resulting in death) Last	c. Demer	ntia a consequence	of):						<u></u>
8760,	cate be executed physicien and the burial-transit	icai E			rtensior	,						
687	ificate g phy: as the			0				1,2000,000				- /
ŏ	death certifica e attending ph ed for use as th	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death		1e				23d. Date of deliv	ery
$\mathbf{\alpha}$		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No	4☐Pregnant at			Ectopic pregnancy Other (specify)	y 	<del></del>		Month	Day Year
P.0.	that the de led by the a detached f	hys	9 □ Unknown 1									
Ś	200	by	Part II. Other significant condit	ions contributing to death b	out not resulting i	in the u	nderlying cause giv	en in Part I.	2		co use contribute to	
ord	v require been si should l	ted								1 ☐ Yes	2L <u>X</u> No 3 Pro	bably 4 □Unknown
Record	e law has b	Completed							24	4a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
E									1[	perform <u>ed</u> ∐Yes 2X	? death? No 1 ☐ Yes	2 🗆 No
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:			Oth	100	of Death (Che			
ō	ding Physician: h. After this certific funeral director,	1.	1 ☐ Yes 2 ☑ No 27. Mapner of Death	1 X Inpatie		utpatien Time of	I 3 DOA	4   Nurs			6 ☐ Other (Speci	fy)
O	ding th: : Afte	tlor	1 ANatural 5 ☐ Pend	28a. Date of Inju ling (Month, Da tigation	y Year)	Injury	28c. Injur Wor M 1 _	rk? ∣Yes 2.∐No	lo			
Division	of or Attending after death. Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could	mined 286. Flace of III)	jury - At home, fa	arm, str	eet, factory, office			cation (Street ty or Town, S	and Number or Rur	al Route Number,
ā	i i i i	Certification;	4 🗆 Hornicide	building, et	tc. (Specify)				,	ty or rown, s	late)	
	Hospitel 24 hours a Funerel I			ing Physician: To the best at Examiner: On the basis o								
	the the	Medical	one)	and manner st	ated.	- 101	29c. Licens					
	S T S T S	-	29b. Signature and title of certifi	SHAMIN						290.	Date signed (Month, $2/8/20$	04.
	1-		2/		d==45 //4== == *	(T	D592	104				•
			30. Name and address of person	im, M. D. 200				aurel,	Mary1a	ınd 20	707-4409	
	Sta	ite	31. Date filed (Month, Day, Yea		rar's Signature							
	Registr		DEC 14	2004	me p	Ø	sporks					

_			1 - State Registrar		artment of Health and M rtificate of Death	ental Hygien	2001 10101
	Physici /Medie		1. Decedent's Name (First, Middle, Last)  Gary C. Turner			2. Date of Death Month Date DECDEMBER	3. Time of Death 3. 7, 2004 11:55a
	Examir	ar	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE S HOSPITAL CENT	TER .	4b. City, Town, or Location of Death CHEVERLY	PR	c. County of Death RINCE GEORGES
	Funeral Director		5. Social Security Number 406-44-8752 6. Sex 12 M 2 □ F 70  Usual Residence of Decedent	In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year February 6	9. Birthplace (State or Foreign Country) 1934 Ohio
	r 28a-f show	tor		Oc. City, Town or Lo			10d. Inside City Limits 1
	th with the 23s or 28s ust be notified	i Direc	10e. Street and Number 4001 Webster Street		10f. Zip Code 20722		itizen of What Country?
920	or Itams	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Eve Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto if 1 ☐ Yes 2☑ No Specify:		14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12th	(Give	dent's Usual Occupation kind of work done during most of workir DO NOT use retired) ic Works	ng .	Kind of Business/Industry
/land	- C	To Be C	17. Father's Name (First, Middle, Last) Unknown			(First, Middle, Maidel rginia Col	•
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (Type, Print) Aija Turner/Daughter	5628	ng Address (Street and Number or Rura Whitfield Chapel	Rd # 302 I	anham, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.	Companyage	'4 □ Donation 5 □ Other (Specify)	Maryland	matory or other place) Veterans 12/16/	04 Chel	ocation - City or Town, State
Bal	permit Depar Impor any in		21. Signature of Europeal Servic Conne	7	2. Name and Address of Facility J. ] 474 Landover Road	Landover,	Maryland 20785
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a condition)	lerotic (	Cardio vascular d		Approximate Interval Between Onset and Death
8760,	certificate be executed nding physicien and ise as the burial-transit	licai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition of the condi				
P.O. Box 6	death e atter id for u	Physician/Mec	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of particle between the past 12 months?  4 Pregnant at time of purchases the particle between the particle betwe	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	sigr d be	by	Part II. Other significant conditions contributing to death but n	not resulting in the u	nderlying cause given in Part I.		use contribute to the cause of death?
al Reco	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 \sum No
Division of Vital Records,	ding Physician: Th. n. After this certificate funeral director, pag	on: To Be	25. Was case referred to medical examiner?  XYYes 2 No  Hospital: 1 Inpatient  27. Manner of Death 1 Natural 5 Pending  (Month, Day Yes)	ZXXER/Outpatien 28b. Time of Injury			
Divisio	i or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (6	- At home, farm, str	M 1 ☐ Yes 2 ☐ No	8f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
_	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of ex and manner stated	amination and/or inv	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause(s d at the time, date an	) and manner as stated. d place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier  M. M. D		29c. License number OCME		tte signed (Month, Day, Year) EMBER 8, 2004
	7)		30. Name and address of person who completed cause of death	111	Print) PENN STREET, BALT1	MORE, MARY	YLAND 21201
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 1 6 2004	Signature April	de		

State of Maryland / Department of Health and Mental Hygiene Reg. No. C Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Dav **Physician** Year  $\mathbf{P}^{\mathsf{M}}$ ROWENA (NMN) TAN DECEMBER 3:15 13 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTE OF HEALTH BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 😿 F 36 Vrs **Director** PHILIPPINES 244-59-5081 OCT. 2, 1968 Usuat Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No VIRGINIA FAIRFAX **SPRINGFIELD** Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7212 HADLOW DR. 22152 PHILIPPINES Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 🌠 No Specify: ASIAN ð 3 Widowed 4 Divorced "neture!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Importent: If item 27 is marked other th any injury or other treumetic event, I've 9DR9. 4 PROPRIETOR **MORTGAGE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROGELIO DEL ROSARIO CARMEN IGNACIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTURO DE LOS SANTOS TAN/HUSBAND 7212 HADLOW DR. SPRINGFIELD, VA 22152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FAIRFAX MEMORIAL PARK DEC 17, 2004 FAIRFAX, VA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DEMAINE FUNERAL HOME 21. Signature of Funeral Service Licensed -00 anits 5308 BACKLICK RD. SPRINGFIELD, VA 22151 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qqset and Death Immediate Cause (Final disease or condition resulting in death) oracorutai DIBTICON Physician dwels /Medical Due to (or as a consequence of): Examiner Lymphi Leucemia he Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit or Attending Physicien: The law requires that the death certificate be executed tailme Due to (or as a consequence of) Box 68760, Aversus Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö the 9□ Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 2 L N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: မ 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Teath 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 1 A Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the within 24 hours after dea To the Funeral Director completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) 0 Center 10 CENTER DRIVE, BETHESDA, MD 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 7 2004 Registrar

1 - State of Maryland / Department of He Registrar Certificate of D	ealth and Mental Hygiene 004 42106
1. Decedent's Name (First, Middle, Last) Physician	Date of Death     Month Day Year
/Medical Antoinette M. varron	December 13, 2004 8:44 P M
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or I	
108 Hannes Street Silver S  Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   Honder Dear	If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
Director 578-42-6810 1□ M 2□xF 70 Yrs. Months Days	Hours Min. (Month, Day, Year) Country)  Jan. 14, 1934 Washington, DC
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Non-training City Continues of the Conti	1 ☐ Yes 2 2 3 No
10a. State 10b. County 10c. City, Town or Location  Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Code  108 Hannes Street 20901  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His	10g. Citizen of What Country?
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	USA
TOB Hannes Street 20901  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☒ No	spanic Origin? (Specify Yes or No- h, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
0 = 5   LL   1 □ Never Married 2√2 Married   1 □ Yes 2 M2 No   1	Specify: Specify: White
1 Never Married 2 Married 1 1 Yes, Specify Cuban 1 1 Yes 2 No 1 1 Yes 2 No 1 1 Yes 2 No 1 No 1 Yes, Specify Cuban 1 Yes, Specify Cuban 1 1 Y	
	uring most of working
0 0 0 1 0	Own Home
17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Guiseppe Ardizzone  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street at	Santa Schiattareggia nd Number or Rural Route Number, City or Town, State, Zip Code)
로 등을 하는 Frank J. Varron, Jr./Husband 108 Hannes Str	ceet, Silver Spring, MD 20901
	Date 20c. Location - City or Town, State
20a. Method of Disposition  20b. Place of Disposition (Name of comptent), crematopy or other place of Heaven  4 Donation 5 Other (Specify)  21 Signature of Euperal Service Licensee	December 16 2004 Silver Spring, Maryland
21. Signature of Funeral Service Licensee 22. Name and Address Francis J.	s of Facility Collins Funeral Home Inc
Tehord L Melin 500 Univers	ity Blvd, W. Silver Spring, MD 20901
shock, or heart failure. List only one cause on each line.	g, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Physician    Immediate Cause (Final disease or condition resulting in death)   As iration Pneumonia	
Examiner Described to (a) as a consequence of ):	*
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Dysplagia  Due to (or as a consequence of):	
fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Cerebrovascular Disease  Due to (or as a consequence of):	
ificate be edical E	
d	23d. Date of delivery
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   1   Unknown   2   Unkn	Month Day Year
1 Yes 2 No 9 Unknown  1 Tyes 2 No 9 Unknown  1 Tyes 2 No 9 Unknown  9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	
\$\frac{1}{2} \frac{1}{2} \frac	
Cerebral Ataxia	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
m m has seed a m m m m m m m m m m m m m m m m m m	24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
The property of the property o	1 Yes 2 No 1 Yes 2 No
" =   U   1   Yes 2 VNO   1   Inpatient 2   FB/Outpatient 3   DOA	26. Place of Death (Check only one)  1. 4 □ Nursing Home 5 □ XResidence 6 □ Other (Specify)
1   Yes 2   XNO   1   Inpatient 2   ER/Outpatient 3   DOA   27. Manner of Death   28a. Date of Injury   28b. Time of Injury   Work   28c. Injury   28c. Inju	
1 Stratural 5 Pending (Month, Day Year) Injury Work 1 Year 1 Year 2 Year 2 Year 2 Year 3 Year	∕es 2 □ No
2 Accident investigation 3 Suicide 4 Homicide   Accident investigation   M   1   Y   28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
The state of the past of my knowledge, death occurred at the time.	e date and place and due to the cause(s) and manner as stated
27. Manner of Death   1 Stratural   2 Stratu	inion, death occurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier 29c. License	number 29d. Date signed (Month, Day, Year)
3 De mil D3	5579 December 15, 2004
30. Name and address of person who completes cause of death (Item 23a) (Type, Print)	Go Bothesda MD 20816
Susan J. Miller, M.D. 6844 Tulip Hill Terra  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registrar DEC 16 2004 Shows B Aparth	

		State of Maryland / Department of Health and Mental Hygiene  State Registrar  Certificate of Death Reg. No. 2 1 1							. 12107		
Physici	an	Decedent's Name (First, Middle, Last)					Mo	te of Death	ay Yea		
/Medic	al	JOSE CANDELAR  4a. Facility Name (If not institution, give si	IO VILLOCH reet and number)		4b. City, Town, or	Location of D	DEC eath		2004 c. County of De	5:18 A <sup>M</sup>	
LAdillii	ici	6026 NEW FORES			WAI	DORF				RLES	
Funeral Director		099-44-7357	7. Age (In yrs. last 90	birthday) Yrs.	If Under 1 Year Months Days		Ain. (Mo	te of Birth onth, Day, Yea 3 . 2 , 19	) (	irthplace (State or Foreign Country) UBA	
show		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	ation					10d. Inside City Limits	
death with the Maryland ms 23a or 28a-f show I mast be notified at	Director	MARYLAND CHARLE	S W	ALDC						1 ☐ Yes 21/21/10	
with the a or 20		10e. Street and Number	a m		10f. Zip Code 20602	,		10g. C	itizen of What (	•	
death ms 23	Funerai	6026 NEW FOREST  11. Marital Status	2. Was Decedent Ever in U.S.	13. W	as Decedent of Hi	ispanic Origin?	(Specify Ye	es or No-	14. Race - An	nerican Indian,	
13-UU30 77 hours after death with the Maryla *natural*, or flems 23a or 28a-f shov Alical Examinat mant be notilized at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	1	Yes, specify Cuba		uerto Rican, CUBAN		Black, Wh Specify: H	ite, etc. ISPANIC	
within 72 hours after ene. than "natural", or Ite	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)	(Give k	ent's Usual Occupa and of work done of O NOT use retired	during most of	working	16b.	Kind of Busines	s/Industry	
be filed within the Hygiene. d other than event, the Hygiene.		12 17. Father's Name (First, Middle, Last)	3	CLER	ICAL WO		Nama (First	Middle, Maide		NS. CO.	
	To Be	NICOLAS VILLOC	Н			AMALI		RRES	n camamo)		
12 Be 2		19a. Informant's Name/Relationship (Type CLAUDIA L. VILL			Address (Street a			_		Zip Code) 20602	
TIOLE, Pages 1 au ent of Hea nt: If item y or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	0000	stery, crem	ition (Name of atory or other plac	· .	Date	L.	ocation - City o		
Dallinor  permit. Pages of Department of the Important: if ite any injury or of once.		21. Signature of Funeral Service Licenses		22.	Name and Address AYMOND	s of Facility				KIA, VA	
	V 18	23a. Part1. Enter the disease, or complic	ations that caused the death. D	X I	A PLATA	, MAR	YLAND	206	46	Approximate	
Physician /Medical	shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):								Interval Between Onset and Death		
Examiner	er	Sequentially list conditions, b.	Due to loras a nonsecusora di								
icate be executed physician and the burial-transit	ai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):								
oor tificate g phys as the	edicai	d.									
The law requires that the death certific the law requires that the death certific are has been signed by the attending page 2 should be detached for use as:	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)				<del>-</del>		23d. Date of d Month	elivery Day Year	
requires that teen signed by	by P	Part II. Other significant conditions cont	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac						co use contribute to the cause of death?		
e law req has been e 2 shou	Completed						24	a. Was an autopsy	prior to	autopsy findings available completion of cause of	
ian: Th ian: Th rtificate	e Col	25. Was case referred to medical				00 Plans of 5		performed?	death?		
ysicia ysicia iis cert direct	To B	examiner?	spital: 1 Inpatient 2 ER/	Outpatient	3□ DOA Othe	26. Place of £ er: 4 ☐ Nursin		/	6 ☐Other (Sp	ecify)	
nding Phy tth. r: After this e funeral d		27. Manner of Death  1 Matural 5 Pending (Month, Day Year)  2 Accident investigation						scribe how inju	e how injury occurred		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Loc Cit	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Hospit 24 hour Funers etely fille	edicai (	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the timestigation, in my op	e, date and pla pinion, death o	ace, and due ccurred at th	to the cause( e time, date ar	s) and manner and place, and du	as stated. ue to the cause(s)	
To the vithin To the comple	Me	29b. Signature and title of certifier	1 0		29c. License		101-	- 1	ate signed (Mor	nth, Day, Year)	
			- Shift	- MI	0 00	0600	150	/	2/19	104	
2	ñ	0. Name and address of person who con	npleted cause. Pleath (fem 23)	a) (Type, P	Penha	nak s	6 5	ule la	. Wa	aldorf MD	
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	L	10-0-	/	/	W 1/1	<del></del>	2000	

ORIGINAL

			1 - For State Registrar	State of Marylar		artment of rtificate of			Reg. No.	04 42108	
	Physici /Media	cal	Decedent's Name (First, Middle, Last  EUNICE E. WILLIAMS  4a. Facility Name (If not institution, give)	0		4b. City, Town,	or Location of	Dec.			
	Examir	ner	Civista Medical			La P1		Death	Char		
	Funeral Director		5. Social Security Number 6. Se 231–12–9689	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 2	Min. 8. Date of Bir (Month, Da		9. Birthplace (State or Foreign Country) VIRGINIA	
Imore, Maryland 2 Pages 1 and 2 should be filed	ith the Maryland or 28a-f ahow e f.olithed at	Director	Usual Residence of Decedent  10a. State 10b. County  MD CHARLES  10e. Street and Number		y, Town or Lo				10g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2√ No  /hat Country?	
	n 72 hours after death with the Marylar "natural", or Items 23e or 28e-1 ahow scleal Examinar must be rediffed at	by Funerai	3659 BROOKWOOD DR  11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	TVE  12. Was Decedent Ever in U Amed Forces?  1	ì	2069 Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		- American Indian, c, White, etc. BLACK	
	within ene. then "	Completed		nly highest grade completed) (Give kind of work done during most of working life DO NOT use retired)						b. Kind of Business/Industry  OWN HOME	
	ould be filed Mental Hygi wrked other letic event, I	To Be C	17. Father's Name (First, Middle, Last)  CLARENCE HAWKINS  SADIE GAINES							iden Sumame)	
	s 1 and 2 sh f Health and item 27 is m other traum		19a. Informant's Name/Relationship (7)  MORRAINE WINFREE  20a. Method of Disposition	(DAUGHTER)	6207		NW WA	Or Rural Route Number SHINGTON , I	DC 20011	State, Zip Code)  City or Town, State	
	permit. Pages Department of Important: If it any injury or o		1X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	BE	THEL C	EMETERY  Name and Adda	1 ress of Facility	2/22/04 PEYTON FUI	NERAL HO		
	Physician /Medical		23a. Part1. Enter the disease, or compleshook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line.	h. Do not ent		ring, such as c	GTON RD, Al ardiac or respiratory a		Approximate Interval Between Onset and Death	
LIVISION OT VITAL HECORDS, P.O. BOX 68/6U,  To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  A Supplication								
	the death certific the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)						of delivery th Day Year	
	equires that en signed by ould be deta	by	Part II. Other significant conditions con	s contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacc						cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown	
	The ate h	e Completed	25. Was çase referred to medical				26. Place o		osy pri med? de 2 No 1	ere autopsy findings available for to completion of cause of eath? Yes 2 No	
	hysic his ce il direc	To B	examiner? 1   Yes   2   No							e 6 Other (Specify)	
	tending Pasth. tor: After the funera	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	tigation M 1 Yes 2 No							
2	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	O	4 Homicide determined building, etc. (Specify)				City or Tov	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	the Hos thin 24 ho the Fun mpletely i	Medicai	(Check only 2   Medical Exami	ner: On the basis of examina and manner stated.	tion and/or inv	vestigation, in my	opinion, death	occurred at the time,	date and place, an	ner as stated.  Ind due to the cause(s)  (Month, Day, Year)	
/	7 6		29b. Signature and title of certifier	Num			200	:29	12/1	7/04.	
<b>*</b>	-(2)		d address person who co			rooke S	Square	Waldorf	Mary1a	nd 20603	
	Sta	ite	31. Date filed (Month, Day, Year)	. Registrar's Signa	ture	R.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND TTEM #2 PER PHY C839 1 PRINGS at A OF Death Reg. No. 2. Date of Death DEC 19, Month 1 Decedent's **Physician**  $p_{M}$ Williams Dec. Bessie Ann 1:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1945 Sept. 19,1945 Jamaica, N.Y 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days Hours 1 □ M 2 □X 186-36-0885 59 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at MD Silver Spring Montgomery 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 2201 Colston 20910 Drive U.S.A. death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. uges 1 and 2 should be filed within 72 hours after of Health and Mental Hyglene.

11 of Health and Mental Hyglene.

12 if few 27 is marked other than "natural", or iten or other traumatic event, it is Medical Expuriment. 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: à Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marketing Specialist TBM 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Fault Velma Williams 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Twin Holly Lane, Silver Spring, Md. 20910 Tysan Williams-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Mt. Lawn Cem. Dec.23,04 Sharon Hill, PA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service License 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nsun /Medical Due to (or as a consequence of) Examiner 21501 HJ 0115 Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai 88 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☑ No Division of Vital Records, P.O. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No 1□ Yes 2 No Hospital or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 2 1 Tes \_2 X0 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death After 5 Pending investigation 1 Natural after death. I Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funaral E 29a, Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

Registrar

29b. Signature and title of certifier

DEC 2 3 2004

HORACIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAPIRO

32. Registrar's Signature

DHMH 17 Rev 1/2001

1300

29c. License number

35826

29d. Date signed (Month, Day, Year)

DECEMBER 19, 2004

PICCARD DR. # 202 ROCKVIlle, Md. 20850

			Pleas	State of Maryland					•	
			1 - For State Registrar	otate of Marytane		tificate of L			2004	42110
	Physici		Decedent's Name (First, Middle, Gill)		Wheel	er, Sr.	1	2. Date of Death Month	Daw. Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, Doctor's Commun	give street and number)		4b. City, Town, or	Location of Death	10000	4c. County of Death Prince (	
	Funeral			S. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9 Birth	place (State or Foreign
	Director		577-42-8461 Usual Residence of Decedent	1⊠ M 2□ F 72	Yrs.	World's Day's		May 1,	1932 Wasi	nington DC
	Marylan I show	tor	10a. State 10b. County  Maryland Prince	e George's	Town or Lo		Marlboro			10d. Inside City Limits 1X Yes 2 □ No
	or 28e	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
	eath w	Funeral	14040 New Acadia	Lane #30	13 \	2077		ify Yes or No-	USA 14. Race - Ameni	can Indian
920	hours after death with the Maryland turet', or Items 23e or 28e-f show at Examiter must be motified at	by	1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	)   .	f Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ican, etc.)	Black, White,	etc.
ဂ်	"na"	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	ition uring most of working	g 16	6b. Kind of Business/In	dustry
N		Con	9th 17. Father's Name (First, Middle, La	ast)		Truck Dri	Ver	(First Middle Ma	Private	2
<u>ھ</u>	ರ್ಷ-೧೯	To Be	Fred Wheeler	1917				phine Pe	,	
Mary	and 2 should ealth and Men n 27 Is marke ler treumetic		19a. Informant's Name/Relationshi Edna J. Wheeler						City or Town, State, Zip er Marlboro	
Baltimore,	iter		20a. Method of Disposition 1 □ Burial 2X Cremation 3	Duelinoval itolii State	ace of Dispo metery, crer	sition (Name of natory or other place	p) Da	ite 20	oc. Location - City or To	own, State
E E	permit. Page Department of Important: If eny injury or once.		*4 Donation 5 Other (Special Signature of Funeral Service) Li			e Cremato . Name and Addres		/2004	Beltsville Funeral H	MD Iome
ñ	Per		Mhh	Tand	9	013 Annap	olis Road	, Lanhan	n MD 20706	Olic
	าเงธ์เติดก		shock, or heart failure. List of Immediate Cause (Final oisease or condition		1 - 1	er the mode of dying  VE H		respiratory arres		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of): ARY	ART	ERY D	DISFA	CF	2 YEAR!
	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque		CARDI	41 INF	FARCT	100	1 DAY
,09	te be executed ysician and he burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a conseque			7111	MICCI	,	
289	tificate g phys as the			d						
ROX	Jeath certificate I attending physi I for use as the b	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
J.	at the de by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
Vital Records, P	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant condition	s contributing to death but not result AUVRE	ting in the u	nderlying cause give	n in Part I.		cco use contribute to the	
900	law re nas bee e 2 sho	Completed	PERICARD	DIAL EFFUS				24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
		e Con	DIARE 25. Was case referred to medical	TES MELL	1TL	2 '	20 Pl. (10 th	performe	death? DNo 1 ☐ Yes	2 No
<u> </u>	Physiclen: this certific al director,	To Be	examiner?	Hospital: 1 4 patient 2 E	R/Outpatien	t 3 DOA Cthe	26. Place of Death ( ir: 4 □ Nursing Home		ce 6 ☐Other (Specif	y)
on of	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	(Month, Day Year)	28b. Time of Injury	Work	at 28 ? 'es 2 □ No	3d. Describe how	injury occurred	
DIVISION	or Atten fter deat Sirector: In by the	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 280 Place of laiunt At hos	ne, farm, str			3f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospitel Within 24 hours a To the Funerel C completely filled	edical Ce	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my know xaminer: On the basis of examination	rledge, death	n occurred at the time	e, date and place, an	nd due to the cau	se(s) and manner as s	tated.
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner stated.	O A	29c. License			I. Date signed (Month,	Day, Year)
	(4)		30. Name and address of person w	ho completed cause of death (Item	23a) (Type:	Print) O	4741	00.0-	12.20.	
	X			ho completed cause of death (Item: 7209 A HANC 32. Registrar's Signatu		PARK	wy OF	perse	LT MI	120773
***	Sta , Registi		DEC 2 2 2004	Bleve & Spanie	the					

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
DEC 2 2 2004

DEC

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ryland / Depa	artment of I		ental Hygier	211111	42112
			Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physic		Clara Offenbacher	Walsh				Month December	Day Yeer 13, 2004	2:55 p M
	/Medi Examii		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	
1			Holy Cross Hospi	tal		Silver	Spring		Montgome	rv
	Funeral		Social Security Number 6. S	7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Yes		thplace (State or Foreign ountry)
	Director		577-60-6323	□M 233F	93 Yrs.	Months Days		April 20,1		ngary
	<b>B</b> -		Usual Residence of Decedent							
	show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	cto	Maryland Montgom	ery	Silver	Spring				1 □ Yes 2 No
	th th or 28 e ro	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	23a	<u>a</u>	3526 Fitzhugh	Lane		209	906		USA	
	ems erm	Funeral	11. Marital Status	12. Was Decedent 6 Armed Forces?	ever in U.S. 13.	Was Decedent of I	Hispanic Origin? (Spe pan, Mexican, Puerto I	cify Yes or No-	14. Race - Ame Black, Whi	
9	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 📆 N If Yes, Give	lo	1 ☐ Yes 2 🔀 No				White
9	iral',	d by	3 🔀 Widowed 4 🗌 Divorced	Year or Dates:					орвену.	
21215-0036	within 72 hours after death with the Maryland nne. than "natural", or Items 23a or 28a-f show 'se Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occu kind of work done	during most of workii	16b.	Kind of Business	/Industry
2	ithin ne.	du	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire	ed)	G	overnmen	t
	filed w Hygiel ther th	ပ္ပ		22	Ace	counts Ma	intenance		rinting	Office
pu	be fil tal H d ott	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid	en Sumame)	
<u>y</u> la	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic svent, Lie M	2	Joseph Offenbach	er			Kathari	ne Distel		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. item 27 le marked other than "natural", or Items 23a or 28a-1 shov giher traumatic svent, Ire Medical Examiner must be notified at		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Stree	t and Number or Rura	l Route Number, Cit	y or Town, State,	Zip Code)
	of Health of Health litem 27 I		Kathryn A. Scrocc	o/Daughter		4 Creeksi	de Drive,	Silver S		
ore	Titer T		20a. Method of Disposition 13 Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo	osition (Name of matory or other pla Of Heave	Decem	ate 20c. ber 16.	Location - City or	Town, State
Ĕ	Pages nent of unt: If it		'4 □Donation 5 □Other (Specify		1	ог неаve emeterv	200		ror Stati	ng, Maryland
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Juneral Service Licen	SOO O			ess of Facility. Collins	Funeral H	omo Tna	ing, cory tollu
m	Depa fmpo any ir		1 margares X	1 ( rle						g, Md 20901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do not en			100		Approximate Interval Between
	Physician		Immediate Cause (Final	1	е.					Onset and Death
	/Medical		disease or condition resulting in death)	a. Sersis	a consequence of):					24 Hours
н	Examiner			500 10 (0. 43 1	a consequence on,					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):					
	be executed sician and burial-transit	Examiner	cause. Enter Underlying that initiated events							
-	exector and and all-tra	Exa	resulting in death) Last	Due to (or as	a consequence of):					
8760,	ate be nysicia he bur	call		d						
89	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edic		· u.						
XO	death certifica attending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
B	atter for t	ciar	in the past 12 months?	1□Live birth 4□Pregnant at		∃Ectopic pregnand ∃ Other <i>(specify)</i>	У		Month	Day Year
o.	the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		,				
<b>a</b>	res that the de signed by the a be detached t	Ph/	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	o the cause of death?
ds	sign d be	d by						1 🗆 Yes	2 <b>X</b> □No 3□P	robably 4 Unknown
0	v requii been s should	ete						2		
Records,	e law has l	Completed					<del></del>	24a. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
E F	: The l	S						1 ☐ Yes 2 🔀 I		2 □ No
Vital	Phyeician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Unanital:		0.0	26. Place of Death	(Check only one)		
of	hye this	٦ ٢	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatie		II 3 DOA	ACCURATION TO THE RESERVE OF THE PERSON OF T	ne 5 🗆 Residence		acity)
		on:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time o	Wo		8d. Describe how in	jury occurred	
sio	Attending or death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1	]Yes 2□No			
Division	I or Attendater death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	iry - At home, farm, st c. (Specify)	reet, factory, office	2	8f. Location (Street City or Town, Sta		ural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Cel								
	losp hou unel	cal	29a. Certifier Certifying Ph	ysician: To the best of	of my knowledge, deat examination and/or in	h occurred at the ti	ime, date and place, a	nd due to the cause	(s) and manner as	s stated.
	he h in 24 the F plete	Medical	one)	and manner sta	ted.				ina piaoo, ana acc	
	To the Hospital within 24 hours a To the Funeral I. completely filled	Σ	29b. Signature and title of certifier	711.	200 10 10	29c. Licen			Date signed (Mont	•
•	4		1 ( little	> /lll	MILLE	AO 200	0056153	Dec	ember 15	, 2004
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)		<del></del>	· · · · · · · · · · · · · · · · · · ·	
			Kristie Nowak,	M.D. 1500	forest G	en Road	Silver Sr	oring MD	20910	
	St	ate	31. Date filed (Month, Day, Year)	32. Hegistra	r's Signature	/				
	Regist	rar	DEC 16 20	104 Sene	10	spark.	2/			

		_	1 - For Stete Registrer	State of Maryla	and / Depa	artment of H	ealth and	Mental Hygi	ene g. No 2004	42113
	Physici		1. Decedent's Name (First, Middle, La:  Diane Louise					2. Date of Death Month		3. Time of Death
	/Medio		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Deat		4c. County of Death	
	Funeral		Laurelwood Car 5. Social Security Number 6. S	ex 7. Age (In yi	rs. last birthday)	Elkton If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,		place (State or Foreign intry)
	Director		Usual Residence of Decedent		J4		J	Februar	y 4,1950	MD
	Marylar -1 show	tor	DE New Cas		<sup>City, Town or Lo</sup> Newark	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣No
	with the a or 28c	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	intry?
36	d within 72 hours after death with the Maryland Jiene. r then "naturel", or Items 23a or 28e-1 show Ithe Medical Examinar must be modified at	by Funeral	#1 Fox Glove  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1		Use 19711 Was Decedent of Higher than 1  Uses 2  Use 1  U	ispanic Origin? (S n, Mexican, Puer Specify:		• S • A •  14. Race - Amer Black, White  Specify: W	
Maryland 21215-0036	within 72 hou ene. then "nature he Medical E	Completed	15. Decedent's Education (Specify only highest grade) Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo )	rking	6b. Kind of Business/li	ndustry
d 21	Hyg Hyg Sthe ent,		12 17. Father's Name (First, Middle, Last,		Di	shwashe		ne (First, Middle, M	Γ/A Truck laiden Sumame)	stop
ylan	Menta Menta arked aric ev	To Be	Albert F. Tay				_	Ann Sad		
	nd 2 s lith ar 27 is r treu		19a. Informant's Name/Relationship (  Ruthann Sarge			ng Address (Street)	ANY STORMSTON	ton, MD	City or Town, State, Zi 21921	p Code)
nore,	S T T		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from State	cemetery, crea	sition (Name of matory or other place	e)	Date 2	0c. Location - City or T	
Baltimore,	permit. Pag Department Importent: I eny injury o		4 □ Donation 5 □ Other (Specif 21. Signature of Furieral Service Licer		22	Cemetery R. Name and Address ndrew G.	s of Facility	uneral	Elkton, M	עו
	₫ O Ξ 6 0		23a. Part1. Enter the disease, or own shock, or heart failure. List only	plications that cau ed the de	1					2-1 0 2 1 Afprixi e Interval Between
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. //E7A	+87A7	1 60	10087	C4		Onset and Death
	Examiner		Sequentially list conditions,	Due to (or as a cons						
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or us a sons	laquenea of):					
,092	te be executed ysician and te burial-transit	cal Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
68			IF FEMALE:	O			8600	1965 18		
O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	23c. If yes, outcome of pret  1 Live birth 2 F  4 Pregnant at time of  9 Unknown	etal death 3[	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
Δ.	w requires that been signed b should be dete	by	Part II. Other significant conditions of	contributing to death but not i	resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	the cause of death?
Vital Records,	The law re cate has be- page 2 sho	Completed						24a. Was an autopsy perform	prior to or	opsy findings available ompletion of cause of
Vita	sicien: certific rector.	o Be (	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	FR/Outpatier	nt 3□ DOA Oth	4	ath (Check only one	nce 6 Other (Speci	6/1
on of	Jing After		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year,	28b. Time o	f 28c. Injun Wor	at	28d. Describe how		97
Division	To the Hospitel or Attend within 24 hours after death To the Funerel Director; / completely filled in by the fi	Certification;	3 Suicide 6 Count be det mined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, office		28f. Location (Streetly or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	Medical	29a. Certifier Certifying Pt (Check only one)	nysicien: To the best of my k niner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the cau arred at the time, da	use(s) and manner as t te and place, and due t	stated. o the cause(s)
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	I		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)	101-	2	) DEC C	DE19720
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Some all beauty markets   Some all beauty					ion, give street an	nd number)		4b. City, Town,	or Location of Deat				
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Physician Medical Examiner  Ph	Ĕ	Page nent c nt: If		1 ☐ Burial 2 ☐ Crematic	n 3 ∐Removal (Specify)	from State		,	· 1	er 14, 200	4 Salish	rv. Marv	land
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State of Maryland / Department of Health and Mental Hygiener 42115 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1900 **EVERETT** DECEMBER 10,2004 WHITE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 317 S DIVISION STREET FRUITLAND WICOMICO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-19-1930 Birthplace (State or Foreign Country)
 MARYLAND 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☑ M 2 □ F 74 213-24-0137 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☐ No Director FRUITLAND MD WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With or items 23a 21826 **USA** 317 S. DIVISION STREET permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature." Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌂 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PAINTER SELF EMPLOYED 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ESTHER BROUGHTON THOMAS WHITE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 E. VINE STREET, SALISBURY, MARYLAND 21804 POLLY WHITE - NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 12-14-2004 DELMAR, DELAWARE \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Lisease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Pres 2 No Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident in by the f within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated 2 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 145049 AF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dausbury MD 21801 CHEIS SNYPER.DO 160 E DEROIL 31. Date filed (Month, 32. Registrar's Signature State 4 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. -James C. Wolfe III State of Maryland / Department of Health and Mental Hygiene State Unpend Item 23a&27 per me G839 Certificate of Death 04 - 3388AKG Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Year **Physician** 20, **JAMES** CLIFTON WOLFE, III 5:19 A.M May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. DEC 2, 1970 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days 1X M 2□ F Yrs 219-82-2112 33 Director MARYLÁND Usual Residence of Decedent Manyland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov treumatic event, if a Madical Examiner must be notified at 1 X Yes 2 No MD Director ALLEGANY CUMBERLAND the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 737 MARYLAND AVENUE 21502 items 23e U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be **JAMES** CLIFTON WOLFE, JR. MARGARET ANN SHIPE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 MARGARET A. WOLFE / MOTHER 34½ VIRGINIA AVENUE, CUMBERLAND, MD 21502 Baltimore, other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State ö permit. Page Department of Importent: If any injury or once. RESTLAWN MEML.GARDENS 05/24/2004 LAVALE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License <sup>22</sup>UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Endocarditis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The faw requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available pajor to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🗆 No Yes Physicien: Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XXYes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c License number 29d. Date signed (Month. Dav. Year) ge and title of certifier 29b. Signa 0 O.C.M.E. May 21, 2004 and address of person ho completed cause m 23a) MD 111 Penn Street, Baltimore, Maryland 21201 MONICA

Registrar

State

31. Date filed (Month, Day, Year)

JAN 05

2005

32. Registrar's Signature

	-	For State	State of	Marylan	-	artment of H rtificate of L		nd Me		- Z 11111	4 62117
		Registrar  1. Decedent's Name (First, Middle	e. Last)			rincate of L	Jeann	2	Rec 2. Date of Death	3. No	3. Time of Death
Physicia		Charles		illiam		Washin	octon	C r	Month	Day Year 18, 20	r ,
/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or			Decembe	4c. County of De	
	•	Memorial Ho	spital			Cumbe	rland			Allega	ny
Funeral		5. Social Security Number	6. Sex 1 M 2 □ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, Y 07/04/19	(ear) 9. B	irthplace (State or Foreign Country)
Director	1	213-40-3710	IBAM ZUF	63	Yrs.				07/04/19	941 Ma	ryland
and and	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
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r 288	rec	10e. Street and Number				10f. Zip Code			100	g. Citizen of What (	Country?
h with	Funeral Director	514 Maryland	Avenue			21502	2			USA	
ems serm	Iner	11. Marital Status	12. Was Dece Amed For	dent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orig	jin? (Spec Puerto Ri	fy Yes or No- can, etc.)	14. Race - An Black, Wh	nerican Indian,
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and and lealth m 27		Bettie L. Washi	ington / w		-	Maryland A		e, Cu Da	_		.502
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Physician /Medical		disease or condition resulting in death)	a Duste (	as a conseq	uence of):	ac zy	-	~~~	_		days
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2/21/2004	,	Allegany Co.		yland / D	epartment of F	Health and M	-	_	1.2110
		Registrar			Certificate of	Death		g. No.	3 37110
Physicia /Medic		Decedent's Name (First, Middle, Last,     GEORGE EDMUNI					2. Date of Deatl Month DECEMBER	Day Yea	
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of De	eath
		ALLEGANY COUNTY N	URSING HOM	E	CUMBER	T,AND		ALLEGA	MY
Funeral		5. Social Security Number 6. Sec	x 7. Age (	In yrs. last birti			8. Date of Birth		Sirthplace (State or Foreign Country)
Director		022-20-5131	]M 2□F 7	6 \	rs. Wortins Days	Hours Will.	8. Date of Birth (Month, Day, JAN. 19,	1928 MAS	SACHUSETTS
pu *		Usual Residence of Decedent  10a. State 10b. County	1	0c, City, Town	or Location				10d. Inside City Limits
show	7			•					1 ☐ Yes 2 XNo
th the Maryla or 28a-f shov e notified at	Sct			RIDGEI					
ith t	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
ath v	ra	14 SILVER STREET			26753			U.S.A.	
r de	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 24 No	er in U.S.	13. Was Decedent of F If Yes, specify Cubi	tispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
or afte	Y.F.	1 Never Married Married	If Yes Give		1 ☐ Yes 2X No			Specify:	WHITE
iral',	d by	3 Widowed 4 Divorced	Year or Dates:					opsoy.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itama 23a or 28a-f show ant, the Maxical Examilier must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication <i>le completed)</i>	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of Busine:	ss/Industry
Athin ne.	idu	Elementary/Secondary (0-12)	College (1-4or 5+)			d)	1	mpi iouza io	001D3137
should be filed within of Mental Hygiene. marked other then matic event, ILE M	S	12			DRIVER			TRUCKING	COMPANY
be fil d off	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	•	·	
should be nd Mental marked ( umatic ev	P	FRANCIS W. WEBB				LOUISE	M. MacA	RTHUR	
12 should be f h and Mental h 7 is marked of traumatic ever		19a. Informant's Name/Relationship (Ty	vpe, Print)	19b.	Mailing Address (Street	and Number or Rura	al Route Number,	City or Town, State	, Zip Code)
Health tom 27 i		JOAN WEBB / WIFE			P.O. BOX 720		GELEY, W		
of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F		20b. Place of cemetery	Disposition (Name of r, crematory or other place		Date 2	20c. Location - City	or Town, State
Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		CUMBERI	LAND CREMATO	ORY /2/2	0/2004	CUMBERL	AND, MD
교육관금 .		21. Signature of Funeral Service Licens	99		22. Name and Addre				
perm Depa Impo any i		(Thomal P).	tencheuc.	,	UPCHURCI	H FUNERAL	HOME, P	.A.	21.502
	-	23a. Part1. Enter the dease, or compl	ic tions that caused th		ot enter the mode of dyir	ENE STREET	or respiratory arre	est,	Approximate
Discontations		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	0011	Artery	Disease	9		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	nury	11				2 mently
Examiner			Due to (01 23 2 0	oriseque los o	т.,				
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence o	of):				
ted nsit	흪	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
xecu al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	onsequence o	f):				
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	caiE								
phys the			o						
ath certificate	Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of o	lalivon
atten for u	ian	in the past 12 months?	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	у		Month	Day Year
at the de by the tached	Physician/Medi	1 □ Yes <del>-2 ⊠No-</del> 9 □ Unknown	9☐ Unknown	io oi deatii	3 Curier (apacity)			+	
that t		Part II. Other significant conditions co	ntributing to death but r	not resulting in	the underlying cause give	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
signe signe	ð	Chronic Olist				labo	1 □ Ye	s 2 □ No 3 🗶	Probably 4 🗆 Unknown
w require been signshould t	Completed by				-				
e 2 s	du						24a. Was an autopsy	prior t	autopsy findings available completion of cause of
The lav	Ö						perform 1 □ Yes 2		y os 2□No
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	9)	
Physician: r this certific ral director,	ဥ	1 □ Yes 2 No	lospital: 1 ☐ Inpatient			4 X Nursing Ho	me 5 ☐ Resider	nce 6 □Other (Sp	pecify)
e fe	ü	27. Manner of Death  1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Ti	ijury Wor	rk?	28d. Describe hor	w injury occurred	
eath. or: A	cati	2 Accident investigation				Yes 2 □ No			
or Attending ufter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (	<ul> <li>At home, far Specify)</li> </ul>	m, street, factory, office		28f. Location (Str City or Town,		Rural Route Number,
	Ö								
Hospital 24 hours a Funeral tely filled	Medicai	29a. Certifier 1X Certifying Phy (Check only 2 Medical Exami	sician: To the best of ner: On the basis of ex	ny knowledge, ramination and	death occurred at the tire.	me, date and place, a	and due to the ca ed at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
the hin 24 the F	led	one)	and manner stated	d.					
or vi Horizon	2	29b. Signature and title of certifier	2hotani	-	29c. Licens			d. Date signed (Mo	
3		<b>▶</b> H.(		_	DS	8853		12/18/	04
50		30. Name and address of person who co			Type, Print) H S	18853 PHOTANI.	MD	1 21-	
			LVANIA		LUMB	ERLAN	ואן וען	0 2150	-
Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1 1	,			

Decidency transfer street, stocks, Lasty  Decidency transfer street, stocks, Lasty  Decidency transfer and street,			State of Maryland / Dep 1- State Amend Item 23a-b&28d per me G84	partment of Health and M Triffcate of Death	ental Hygier	ne 2004 42119
4. Sealth year of root established, year street and number)  7. 195.2 O A KNOOD LANE  FURTHER DISTRICT  100. Since of the street					Month E	Day Year
231—68 - 8379   10 - 28	Exam	iner	7952 OAKWOOD LANE	POMFRET	8. Date of Birth	CHARLES
The property of the property o	Directo		231-68-8379 <sup>1□M 2</sup> ♥F 55 Yrs.	Months Days Hours Min.	(Month, Day, Yea	(Country)
The property of the property o	e Maryland 3a-f ehow	ctor				
The property of the property o	ter death with th Items 23a or 26		7952 OAKWOOD LANE           11. Marital Status         12. Was Decedent Ever in U.S. Amned Forces?         13. Marital Status	20675 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I		U.S.A. 14. Race - American Indian,
The property of the property o	n 72 hours af	þ	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki	ng 16b.	WHITE
23a Part Lefter the disease, or complications fish caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control final disease or complications fish caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control final disease or complications fish caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control final disease or complications and Death (control final disease).  23a Part Lefter the disease, or complications fish caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control final disease or complications and Death (control final disease).  23a Part Lefter the disease, or complications fish caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the control final disease or complications and Death (control final disease).  23a Part Lefter the disease, or complications in the cause of death (control final disease).  23a Part Lefter the disease, or complications the cause of death (control final disease).  23a Part Lefter the disease, or complications the cause of death (control final disease).  23a Part Lefter the disease, or complications to control final disease or complications and death.  23b Part Lefter the disease, or complications to control final death.  23c Part Lefter the disease, or complications to control final death.  23c Part Lefter the disease, or complications to control final death.  23c Part Lefter the disease, or complications to control final death.  23c Part Lefter the disease or completed cause of death.  23c Part Lefter the disease or completed cause of death.  23d Date for death.	IG CIC e filed within til Hygiene. other then		Elementary/Secondary (0-12) College (1-4or 5+) 12 ACCO	UNTANT		
23a Part Little the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control of the subject of the subject to the subject of the subject to t	Should be not marked umatic ex	To E				
23a Part Error the disease or complications fish caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and provided and provid	dartimore, mi mut. Pages 1 and 2 spartment of Health a portent: If item 27 is by injury or other tra		20a. Method of Disposition  1 □ Burial 2 (XCremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify) METROPOLITIAN  21. Signature of Funeral Service Licensee M () () 4.7.9	position (Name of ematory or other place)  CREMATORY 12-24  2. Name and Address of Facility	20c. 1-04 AL	Location - City or Town, State  EXANDRIA, VA
FEMALE   23d. Mas decedent pregnant   1   Live birth   2   Fetal death   4   Pregnant at time of death   4   Pregnant at time of death   5   Other (specify)   Month   Day   Year   1   Year   2   2   2   2   2   2   2   2   2	Physician /Medica Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter U denying Cause (Disease or injury)	LA PLATA, MARYLA	ND 206	46 Approximate Interval Between
The property of the property o	a si si si si	by Physician/Medicai	Due to (or as a consequence of):  d	Other (specify)		Month Day Year  Duse contribute to the cause of death?
1   Natural 2   Accident 3   Suicide 4   Homicide   Suicide 5   Suicide 4   Homicide   Suicide 6   Suicide 4   Homicide   Suicide 6   Suicide 6   Suicide 7   Suicide 7   Suicide 8   Suicide 9   Suicid	i: The law req cate has been page 2 shou				autopsy performed?	prior to completion of cause of death?
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year) 32. Registrar's Signature	ttending death.	To B	examiner?  t:Z  Yes 2   No	ont 3 DOA Other: 4 Nursing Hon of 28c. Injury at Work?  PM 1 Yes 2 No	186. Location (Street a City or Town, Sta	and Number or Rural Route Number, 169 7952 Oakward Iv.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1655 W. NeS-D Pl. La plus MD Za 6 ist6.	To the Hospit within 24 hours To the Funere completely fille	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	nvestigation, in my opinion, death occurre	nd due to the cause d at the time, date a 29d. D	(s) and manner as stated.  nd place, and due to the cause(s)  Date signed (Month, Day, Year)
Registrar IAN 0.4 2005			30. Name and address of person who completed cause of death (Item 23a) (Type	14 MD 20646.		

		1 - For Amend Item Registrar	23a State 6	of Maryla d per i	nd Gepa ie G841	argment of H rtificate of I	lealth and tas Death	Mental Hyg	giene 20	104	4212
W 15		1. Decedent's Name (First, Middle						2. Date of Dea	ath		. Time of Death
Physicia /Medic		WILLIAM EUGI		IGHT,	JR.				0, 200		4:30 PM
Examin	er	4a. Facility Name (If not institution, 7952 OAKWOOD		umber)		4b. City, Town, or POM	·Location of Dea IFRET	th	4c. County o	of Death • A •	
Funeral Director		5. Social Security Number 219-48-9198	6. Sex 1 💢 M 2 🗆 F	7. Age (In yr:	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da)	y, Year)	Country)	(State or Foreign
D D		Usual Residence of Decedent						AUG.23	,1947	VIRG	INIA
Aarylar f show	ō	10a. State 10b. County		10c. C	City, Town or Lo						Inside City Limits  1 ☐ Yes 2X No
n the l	Director	MARYLAND CHAI  10e. Street and Number	RLES			POMFRE 10f. Zip Code	T		10g. Citizen of W	hat Country?	
23e o		7952 OAKWOOD	LANE			206				S.A.	
s 1 and 2 should be filed within 72 hours after death with the Maryland is a tand 2 should be filed within 72 hours after death and Mental Hygiene item 27 is marked other than "natural; or iteme 23s or 28s-1 show other treumatic event, the Madical Examinal must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Marrie  3 □ Widowed 4 □ Divorced	Armed F	<b>2</b> ∕∑No ive		Was Decedent of Hi fYes, specify Cuba I□Yes 2 🖾 💑	spanic Origin? (§ n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race Black Specify:	- American II , White, etc. WHI	
72 hour	Completed b	15. Decedent' (Specify only highes	s Education		16a. Deced	ient's Usual Occupa	ation during most of we	nkina	16b. Kind of Bus		
within ene. than	dmo	Elementary/Secondary (0-12)	T	(1-4or 5+)	life. I	BODY TE	) -	-	DM WAC		MO DODY
d 2 should be filed within 72 hours aft do and Mental Hygiene. 77 is marked other than "natural", or treumatic event, the Medical Exam.	Be Co	17. Father's Name (First, Middle, L	.ast)		AUIO	BODI II		me (First, Middle,			TO BODY
should by	<b>To E</b>	WILLIAM EUGE		HT, SR				LEOLA			
and 2 sho saith and n 27 is m		19a. Informant's Name/Relationsh JONATHAN D. 1	, ,	SON		g Address (Street a			_	State, <i>Zip Coo</i> 20675	(e)
ss 1 and 2 of Health item 27 other tr		20a. Method of Disposition		20b.	Place of Dispo			Date	20c. Location - 0		State
mit. Pages 1 ar partment of Hea portant: If item: y injury or othe		1 ☐ Burial <b>X</b> Cremation 1 ☐ Donation 5 ☐ Other (Sp	ecify) M	ETROPO	•	N CREMAI	· .	-24-04	ALEXANI	DRIA,	VA
permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other		21. Signature of Funeral Service L	lon	0479		Name and Address AYMOND A PLATA	FUNERA , MARY	<u>LAND 20</u>	646		
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to	Asphyxi (or as a conse	a equence of):	4 .	g, such as cardia	c or respiratory are	rest,	Inte	proximate erval Between set and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	Car Exh							
	dical Examiner	resulting in death) Last	c. Due to	(or as a conse	equence of):						
il is	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregi birth 2 Fe inant at time of nown	tal death 3	Ectopic pregnancy Other (specify)		15.	23d. Date Mont	of delivery th Day	Year
quires that n signed by		Part II. Other significant condition	ns contributing to	death but not re	esulting in the ur	nderlying cause give	on in Part I.		bacco use contrib		use of death?
The law requir cate has been si page 2 should	Completed	3						24a. Was a autops perform	sy pr med? de	ere autopsy f for to complete ath?	indings available tion of cause of
ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			04	The state of the s	ath (Check only or	10)		
ding Ph After th funeral	Certification: To	27 Manner of Death 1 Natural 2 Accident investig 3 Suicide 6 Could n 4 Homicide	ation 12/2 28a. Date (Monot be bed) 28e. Place build	of Injury oth, Day Year) c <sup>1</sup> / c — t e of Injury - At ding, etc. (Spec	ER/Outpatien  28b. Time of Injury  4:30  home, farm, straity)	28c. Injury Work	4 Linutaling r	car exha	ow injury occurre	Subjec	t inhale
spite ours ierel filled	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the kaminer: On the l	e best of my kroasis of examination	nowledge, death nation and/or inv	occurred at the tim restigation, in my op	e, date and place sinion, death occi	and due to the c	ause(s) and man	hmo ner as stated	2005
To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier				29c. License	number	2	29d. Date signed	(Month, Day,	Year)
		yalia m.	la gov.	rims	>	Da	5508	383	いれて	104	
15		30. Name and address of person v	no completed cau	se of death (Ite	em 23a) (Type,	Print) U 200	467				
Sta	e	31. Date filed (Month, Day, Year)	2005 32.1	Registrar's Sign	nature	- 200					
Registra	ar	JAN 0 4	2005	Colores o	KA	rack D					

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ORIGINAL

			1 - For State Registrar	State of M	aryland ,		rtmen tificat					Reg. I	200L	, l	+2121
	Physici		Decedent's Name (First, Middle,     BAOYING	Last)	>	KIE					2. Date of D Month DeC.		2004 <sup>Ye</sup>	ar	3. Time of Death 12:35P M
	/Medic Examir		4a. Facility Name (If not institution,				-		Location of	of Death			4c. County of D	eath	
			Shady Grove	Adventist						0411			TOOM		
	Funeral Director		5. Social Security Number 219-67-9501 Usual Residence of Decedent	i. Sex 7. Ag 1 ☐ M 2 🛣 F	je (In yrs. last	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, D Aug • 2	irth ay Yea	1941 C	Birthplac Country NIN	ce (State or Foreign a
	Maryland -I show lied al	tor	10a. State 10b. County	GOMERY	10c. City, T	own or Loc		e						10d	I. Inside City Limits 1 H Yes 2 □ No
	or 28s	Director	10e. Street and Number	_			10f. Zip						Citizen of What	Country	/?
	s 23a	erai	405 Great Fall	Ls Road	Cupris II C	12.14		0850		-:-0 (0-	-4.14		China		1
920	be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "natural", or items 23a or 28a-1 show ovent, the Mcdical Example invalled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	Armed Forces?			Yes, spec		spanic On n, Mexicar Specify:	gin / (Spo i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify:		).
15-0	n 72 ho "natura kdical P	Completed	15. Decedent's (Specify onfy highest	grade completed)		6a. Deced (Give I	ent's Usua kind of woi	al Occupa rk done d	ition Juring mos	t of work	ing		Kind of Busine		
212	filed within Hyglene.	Comp	Elementary/Secondary (0-12) 9th	College (1-4or t	5+)		leri								
land	ould be fil Mental H arked ott etic even	To Be	17. Father's Name (First, Middle, La Gengshen	Xie							e (First, Middle Omei	e, Maide Xi			
Mary	S DEE		19a. Informant's Name/Relationship Xiaolan Zhang		1	9b. Mailin	g Address Grea	(Street a	nd Numbe	r or Rura Rd	Rock V	ber City	or Town, State	e, Zip Co 20	850
Baltimore, Maryland 21215-0036	Pages 1 and 2 nent of Health a nent of Health a lint: If item 27 lary or other tree		20a. Method of Disposition  1 ☐ Burial 2 🌠 Cremation 3  4 ☐ Dongton 5 ☐ Other (Spe		20b. Place ceme Meti	tery/cre#	sition (Name natory or of nr1	ther place			Date 14/04		Location - City		
Baltir	permit. Page Department of Important: If any injury or once.		21. Signatule of Ameral Service Lie		ucel	22.	Name an	d Addres	s of Facilit	y Sno	owden	Fu		Hom	e,P.A.
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	cate be executed xx x by yesician and the buriat-transit and the bur	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b											
.O. Box 687	the death certifi y the attending p ched for use as	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √o 9 □ Unknown	d.  23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal dea		Ectopic pro						23d. Date of Month	delivery Da	ıy Year
ds, P		by	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the un	derlying ca	use give	n in Part I.				use contribute		cause of death?
	ilcien: The law requires certificate has been sign rector, page 2 should be	e Completed	25 Wee								24a. Was auto perf 1 \( \text{Yes}	psy ormed?	death	?	findings available etion of cause of
Ž	Physician: this certific ral director,	OB	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Monatie	ent 2 ER/	Outpatient	3 🗆 DO	Δ Othe	-		Check onl		6 □Other (S	nanifu)	
	Jing After fune	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da		Time of Injury		Bc. Injury Work		2	28d. Describe			о <del>в</del> спу)	
É	ial or Attandi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine			farm, stre	et, factory	, office		2	28f. Location ( City or To		and Number or te)	Rural R	oute Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edicai (	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examination	dge, death and/or inve	occurred a estigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause( date ar	s) and manner nd place, and d	as state ue to the	d. e cause(s)
١		Ž	29b. Signature and title of certifier	_				License	number	8	-	_	ate signed (Mo	-	
	2		20 Name and address of person wh	o completed cause of d	leath (Item 23a	a) (Type, P	Print)					-			1,200
		-	Robert Kirkea	ly, MD 98	01 Me	dica	1 Ce	ente	r Dr	Ro	ckvil	le,	MD 208	350	
	Sta Registr	. 4	31. Date filed (Month, Day, Year)  DEC 14 2		ar's Signature	9	Spa	eks)	/						

State of Maryland / Department of Health and Mental Hygiene 2 🕦 🛭 👃 42122 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year YOUNG OLLIATE December 18. 2004 /Medical 4:53 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Buckingham's Choice Health Care CenterAdamstown Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral**  Birthplace (State or Foreign Country) 1**X** M 2□ F Director 80 009-12-7281 Sept. 6, 1924 | Illinois Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f shover the Medical Examiner must be recitied at Director 1 ☐ Yes 2 🖾 No Maryland Frederick Adamstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle, Apt. I-214 21710 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 Specify: Wh<u>ite</u> 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than Elementary/Secondary (0-12) Dept. of Labor College (1-4or 5+) 4 Supervisor US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Heath Young Barbara Holgate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anne M. Young, wife 3200 Baker Circle, Apt I-214, Adamstown, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Its eny injury or ot once. 1 Burial 2 XCremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12/19/2004 Smithsburg, Maryland permit. 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licensee MO0999 106 East Church Street, Frederick, MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21701 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): 68760 attending physician Physician/Medical Box ( IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Dav Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No the 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 2 certificate has 1 🗌 Yes 2X No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2X No Hospital: P 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attanding 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the f 2 Accident 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signatore and tip of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mitul Dave', 3200 Baker Circle, Adamstown, MD 31. Date filed (Month, Day, Year) 32. Register's Signature DEC 2 0 2004 > Registrar

			1- For State of Maryland / De	partment of Health and I Pertificate of Death	Mental Hygier	
ı	Physici		Decedent's Name (First, Middle, Last)     MARY MAE ZAGRODNICHEK		2. Date of Death Month DEC - 22	Day Year 3. Time of Death 4:00 An
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4103 PORT TOBACCO RD.	4b. City, Town, or Location of Death	1	4c. County of Death CHARLES
100	Funeral Director		5. Social Security Number 214-60-6388  Usual Residence of Decedent  6. Sex 1 M X F 52  7. Age (In yrs. last birthd) 8. Sex 1 M X X F 52	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea FEB.1,19	
	ne Maryland 8a-f show	Director	10a. State 10b. County 10c. City, Town of MARYLAND CHARLES NANJEM	ОУ		10d. Inside City Limits 1 □ Yes 2 🛣 💑
ထ	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "natural", or itema 23e or 28e-f show event, the Medical Examinational templied at	by Funeral Dire	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXVo	10f. Zip Code  20662  3. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puert		U • S • A •  14. Race - American Indian, Black, White, etc.
215-0036	within 72 hours a ene. then "natural", c	Completed by	3 ★ Widowed 4 □ Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	1 ☐ Yes ★↑↑No Specify:  seedent's Usual Occupation five kind of work done during most of work a. DO NOT use retired)	king 16b.	Specify: WHITE.
and 2121		To Be Con			ne (First, Middle, Maid ATHERINE	
, Maryland	s 1 and 2 should be i Health and Mental itam 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Ru  6 HANSON ROAD, W	ıral Route Number, Cit	y or Town, State, Zip Code)
Baltimore,	t. Page rtment o rtant: If sjury or		***Surial 2 Cremation 3 Removal from State cemetery, of	oposition (Name of crematory or other place)  ORIAL GDNS 12-  22. Name and Address of Facility	28-04 V	Location - City or Town, State
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	RAYMOND FUNERAL LA PLATA, MARYL enter the mode of dying, such as cardiac  LE LOIO LE	AND 20646	Approximate Interval Between Onset and Death
8760, ツ	death certificate be executed  Radian death certificate be executed to a strength of the service	Ilcai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):			
O. Box 6	that the death certifica ed by the attending pt detached for use as t	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	The law requires that the te has been signed by the bage 2 should be detache	by	Part II. Dther significant conditions contributing to death but not resulting in th	a underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?  2 No 3 Probably 4 Hunknown
r		Completed			24a. Was an autopsy performed?	
Vital	slcien: Th certificate irector, pag	Be c	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	th (Check only one)	0 F00 (0 Y
Division of	ng Ph (fter th	ation: To	1   Yes 2   No	e of 28c. Injury at	ome 5 Residence 28d. Describe how in	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, Sta	
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in	Medical	29a. Certifier (Check only one) (Check one) (Check only o	r investigation, in my opinion, death occu	rred at the time, date a	and place, and due to the cause(s)
	Ywit To		29b. Signature and title occentifier  HOUSE TO COLL  30. Name and address of parson who completed cause of death (Item 23a) (Type	29c. License number  D J & 3 5	7 1	Date signed (Month, Day, Year)
	∫ <b>(</b> )	ite_	30. Name and address of person who completed cause of death (Item 23a) (Ty. 23a). Date filed (Month, Day, Year) 32. Registrar's Signature	LaPlate	, M	0 20646
	Registr		JAN 0 4 2005 Kenny 1	Since !		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Pegistrar AMEND ITEM #10b PER FH G839 97666 956 966 Death 2. Date of Death Physician 1:15 PM tnoers on /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Randallstown Amore If Under 24 Hrs. Social Security Number (In yrs. last birthday, 53 Yrs. 9. Birthplace (State or Foreign **Funeral** 217-50-9600 Director Usual Residence of Decedent 10b. County BALTIMORE 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23s or 28e-f show the Medical Examiner rust be netitied at 1 Yes 2 No Director MARYLAND NDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? 28 0 MOND KIDGE USA Funeral 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced ACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be ELMO WILLIAM LOUISE Si 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu once. SISTER) 6 APT. F. BALTO, MD. 21225 HAZEL WHITE 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition or other place) 1. Surial 2 ☐ Cremation 3 □Removal from State CEMETERI! 01-10-05 ANSDOWNE, MARYAND \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility BROWN JR. FUNERAL HOME TON AVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebra Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical use as attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 2 🗆 No 2□No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 2 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number M.D. ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

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32. Registrar's Signature

MD 5401 Old Court Road Randallstone

			For State Registrar	State of Maryland /	Department of Health and I Certificate of Death	Mental Hygier	211116	42125
	Physici	an	1. Decedent's Name (First, Middle, Last)	Austin	oonouto or pour.	2. Date of Death	Day Year	3. Time of Death
	/Medic	al	Rommie 4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	December	31 2004 4c. County of Death	2130 M
			906 North Ker 5. Social Security Number 6. Sex,	7. Age (In. yrs. last bi	Baltimore inthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director		218-47-3287	M 20 F 65	Yrs. Months Days Hours Min.	219/19	ar) Cou	SINIA
	show		Usual Residence of Decedent  10a. State  10b. County	10c. City, Tov	vn or Location			10d. Inside City Limits
	28a-1 s	Director	10e. Street and Number	HCI	10f. Zip Code	10g.	Citizen of What Cou	1 Ves 2 No intry?
	ath with	ral Di	900 N. KENU	DOD AVE.	21705	UI	NITED	STATES
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland to of Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23a or 28e-1 show or other traumatic evant, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 D No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	I within 72 h iene. rthan "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		a. Decedent's Usual Occupation (Give kind of work done during most of world life. DO NOT use retired)  STEVEDOR	rkina	. Kind of Business/In	JAI TRADE
Maryland 2	2 should be filed and Mental Hygir is marked other raumatic evant.	To Be C	17. Father's Name (First, Middle, Last) Rommie	IURRAY _	ESTE	ne (First, Middle, Maid UE AU	STIN	
re, Mar	permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is m eny injury or other traum <u>once</u> .		19a. Informant's Name/Relationship (Typ ESTELLE FRISBY / 20a. Method of Disposition	PARENT 9	b. Mailing Address (Street and Number or Ru CLAN KENNEY PA of Disposition (Name of	UE. BAUTI	ty or Town, State, Zij L. Location - City or To	D 21205
Baltimore,	Pages tment of tant: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Onation 5 ☐ Other (Specify)	imoval from State ANAT	ony, crematory or other place) ONY GIFTS REG. 1/1	105 H	ANONE	e, MD
Ba	permit Depar Impor eny in		21. Signature of Furgari Service License	3	22. Name and Address of Facility  Daugherty Family  2601 Mou	y Funeral Home And ntain Road - Pasa	i Cremation Cent	er, P.A.
Ţ			23a. Part1. Enter the disease, of complic shock, or heart failure. Hist only one Immediate Cause (Final	ations that eaused the death. Does cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	#0110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1110, 1	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Metastatic  Due to (or as a consequence	Direction of the second	cancer		Year
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.O. Box	that the death certified by the attending of detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	rery Day Year
۵.	8 5 0		Part II. Other significant conditions conf		in the underlying cause given in Part I.		o use contribute to t	the cause of death?
Records,	> 0 75	Completed by	Congestive her	+ failure		1 ☐ Yes	24b. Were auto	opsy findings available
al Re	The ate h page	Comp				autopsy performed 1 ☐ Yes 2 ☑	? death?	ompletion of cause of
f Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/O	Other	ath (Check only one)  Home 5 esidence	6 □Other (Speci	ify)
ion of	After fune		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how in	njury occurred	
Division	al or Atta after de i Directo d in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, the building, etc. (Specify)	farm, street, factory, office	28f. Location (Street City or Town, St		al Route Number,
	To the Mospital or Attanding Pr within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	edicai C			ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occu			
1	To the within 2. To the complet	2	29b. Signature and title of certifier		29c. License number  N - 005 8893		Date signed (Month,	
/	2/1		30. Name and address of person who cor		) (Type, Print)		R. II	2005 1more
	Sta	ate	31. Date filed (Month Day, Year)  JAN 0 6 201	Johns Hepki 32. Jegistrar's Signature	ns 401 North	Breadway	1 Dart	INVOY E
h	Regist	rar *	JAN 0 6 200	15 prives &	South			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -30, Month **Physician** 7:00 A Jessie Allen December 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Carriage Hill-Bethesda Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 25, 16 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 397-16-6636 98 Yrs 1906 Wisconsin Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count r than "natural", or Itams 23a or 28a-1 show the Medical Examinar must be nutilised at 1 ☐ Yes 2 📉 No Director Maryland | Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 United States 5215 West Cedar Lane filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give 1943-1966 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Army Sergeant markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 is marked other. Alex C. Allen Margaret Jane Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tennyson A. Townsley/ Trustee 148 Jennifer Road, Annapolis, Maryland 21401 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Arlington
tional Cemetery 00 Jan. 11, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department. Important: If any injury or once. Arlington, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 National 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland, 20814 Millian a. insylver M01173 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrhythmia /Medical Due to (or as a consequence of): Examiner Hypertension years Sequentially list conditions, if any, isaling to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Atherosclerotic Cardiovascular Disease years and Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💢 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Dementia been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 2∏ No 2X No 1 Yes or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Momicide To the Hospital within 24 hours a To the Funeral ( 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 3, 2005 D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, M.D. 6844 Tulip Hill Terrace, Bethesda, Maryland 31. Date filed (Month, Day, 32. Registrar's Signature State Brasles Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hallie Μ Bryant December 31 2004 9:59 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 81 Director 216-20-6114 July 8, 1923 Tennessee Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at Director Anne Arundel 1 ☐ Yes XX No MD Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1905 Sheffield Court 21144 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. I progremit if item 27 is marked other than "neturel", or item any injury or other treumatic event 1 ☐ Yes ŽXNo If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify African American δ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E. Howard Morrow Mabel Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bryant/husband 1905 Sheffield Court, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Crownsville Veterans Cem. Jan. 7, 2005 Crownsville, MD. ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road, Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SUDSIS /Medical Dualto (or as a consequence of) Examiner tension Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last ud to (or as a consequence of): Examine -transit Due to (or as a consequence of) the burialphysician P.O. Box 68760 Physician/Medical as attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? DICIDENTS MEIL 1 ☐ Yes 2 ☐ No 2 DNo or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Yes 2 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pendina 1 Natural 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd, Baltimore, MDZ1239 namion 31. Date filed (Month State Registrar

			. For	State of Maryla	and / Depa	artment of Health	and Menta	al Hygiene	2001	1 - 1
			1 - State Registrar		Cei	tificate of Deat	h	Reg. No	2004	42128
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	Funeral Director		5. Social Security Number 6. Sex 1 M		rs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Da	te of Birth onth, Day, Year)	9. Birth	place (State or Foreign
	/iand		Usuel Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	the Mary 28e-f sh	ector	M D  10e. Street and Number		B < 1.	10f. Zip Code		10- 6	tizen of What Cou	1 No 2 No
	th with 23a or	al Di	700 Washingto	in Place	Apt SA	71701		()()	ITED S	TATES
036	be filed within 72 hours after death with the Maryland ntal Hygiene. et other then "naturel", or Items 23a or 28e-f show event, the Medical Examination matter rolling Later.	by Funeral Director	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Nas Decedent of Hispanic C f Yes, specify Cuban, Mexic Per 2 No Specifi		etc.)	14. Race - Americ Black, White, Specify:	can Indian, etc.
15-0	"natur	leted	15. Decedent's Educati (Specify only highest grade co	on ompleted)	(Give	lent's Usual Occupation kind of work done during me DO NDT use retired)	ost of working	16b. K	ind of Business/In	dustry
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Maryland	should be find Mental H marked of marke of	To Be	17. Father's Name (First, Middle, Last) WILLIAM (A)	DLER		18. Mot	ther's Name (First, ARGRE	Middle, Maiden	SCOT	1
Mar	O1 (0 00 m		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street and Num	ber or Rural Route	Number, City of	or Town, State, Zip	Code)
ore,	es 1 and 2 of Health I item 27 I		20a. Method of Disposition		Place of Disposemetery, crem	sition (Name of natory or other place)	Date	20c. L	ocation - City or To	own, State
Baltimore,	permit. Pages 1 a Department of Hes Importent: If item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	VATOMY (	SIFTS REG.	12/30/0	X HA	NOVER	1,mD
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Ŀ			23a. Part 1. Enter the disease of complications shock, or heart failure. List only one of immediate Cause (Final	ause on each line.	eath. Do not ente					Approximate Interval Between Onset and Death
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P.O. Box	0 0	Physician/M	23b. Was decedent pregnant in the past 12 moeths?	If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)		_	23d. Date of delive Month	ery Day Year
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Vit	Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hosp	oital: 1 Inpatient 2	☐ FR/Outpatient		ce of Death (Chec Nursing Home 5		€ □Other (Specif	
n of	ing Phys Wer this uneral di	on; T		28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?		escribe how injur		7
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ă	urs after rel Directled in by		4 Homicide	building, etc. (Spe	cily)		City	y or Town, State	)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physicia (Check only one) 1 Medical Examiner:	an: To the best of my k On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time, date a estigation, in my opinion, de	and place, and due eath occurred at th	e to the cause(s) e time, date and	and manner as st I place, and due to	ated. the cause(s)
	To Toon	×	29b Signature and title of certifier	12/	-	29c. License number	1040	29d. Dat	e signed (Month, )	Day, Year) DY
	011		30. Name and address of person who compl	leted cause of death (It	MD	John, 1	tople.	Hospi	<del> </del>	
	Sta Registr	- 4	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	ade	1			
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			For State Registrar	400	State of I	Marylan			t of H	ealth a		-		Z	l,	421	29
	Disconini		1. Decedent's Name (First, Mic	dle, Last	)							2. Date of De		av `	/ear	3. Time	
	Physicia /Medic		Barrie S. B	asto	n							Decemb				2:28	8 Рм
	Examin		4a. Facility Name (If not institut	ion, give	street and numb	er)		4b. City, 7	Town, or	Location of	of Death		4	c. County of	Death		
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	Funeral		5. Social Security Number 267–96–0049	6. Se	x ΩM 2□F /.	Age (In yrs. 57	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	y, Yea	10/17	Cour	lace (State try)	or Foreign
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	th the	Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of Wh	nat Cour	try?	
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lan	2 sho and is mu		19a. Informant's Name/Relation	nship (T)	ype, Print)		19b. Maili	ng Address	(Street a	ind Numbe	er or Rura	Route Numb	er, City	or Town, S	tate, Zip	Code)	
	교육성급		Timothy B. B	asto	n/ Broth					k Cou		Germani					374
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				, , , , , , , , , , , , , , , , , , , ,	Certificate of	Death	R	eg. No.2 () () 4	42130
			Decedent's Name (First, Middle, Last)				2. Dete of Deat Month	h Dey Year	3. Time of Death
	Physici		Vera Louis	e Barreca	a			r 28, 2004	5:35 AM
	/Medio Examir		4e Fecility Neme (If not institution, give street	nd number)		4b. City, Town, or L	ocation of Death	4c. County of Dee	th
			Manor Care Potomac			Potomac		Montgo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. lest	Months   Davs		8. Date of Birth (Month, Day, Nov. 29,	Yeer) 9. Bir	thplace (State or Foreign ountry)
	Director		112-09-0736	89	Yrs.		Nov. 29,	1915   New	Jersey
	D		Usuel Residenca of Decedent  10a. Stete 10b. County	10c. City. To	own or Location				10d. Inside City Limits
	anyla show	٦	- Control of the cont						1 ☐ Yes 2 🖔 No
	he N	Director	Maryland Montgomery  10e. Street end Number	POLO	Omac 10f. Zip Code		1	0g. Citizen of What Co	ountry?
	with with	ᡖ		T	·	<b>-</b> /			
	sath	Funeral	10714 Potomac Tennis  11. Merital Status 12. Wa	Lane is Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cu			United Sta	
	ter d them	5	1 Never Married 2 Married 1	ned Forces? ]Yes 2 No			Rican, etc.)	Black, Whit	te, etc.
20	n 72 hours after death with the Maryland "natural", or Hems 23a or 28a-f show solical Examinet must be notified at		If Y	es, Give ar or Dates:	1 □ Yes 2 No	Specify:		Specify:	White
Ö	2 hou	Completed by	15. Decedent's Education		6a. Decedent's Usuel Occi	upation	ina	16b. Kind of Business	/Industry
215	c ' =	pie	(Specify only highest grede comp Elementary/Secondary (0-12) Co	llege (1-4or 5+)	(Give kind of work don life. DO NOT use retir	e during most of work red)	ang	Fabric	
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b	be filed withintal Hygiene.	Be	17. Fether's Name (First, Middle, Last)				•	Maiden Surname)	
<u>a</u>		ToE	Joseph Baffa	_		Unknown	1		
a	A DE L		19a. Informant's Name/Relationship (Type, Pri	int)	19b. Mailing Address (Stree	et and Number or Ru	rei Route Numbei	r, City or Town, State,	Zip Code)
Σ	D = 1 =		Carol Trawick/niece		6600 Elain L	ane, Beth			817
ore.	of Heal Item 2 r other		20a. Method of Disposition  1 ☐ Burial 2 🕅 Cremation 3 ☐ Remove	come	e of Disposition (Name of etery, crematory or other p	lace)	Dec.	20c. Location - City or	Town, State
Ĕ	Page nent o int: If		4 □ Donation 5 □ Other (Specify)		omery Crematori	um, Inc. 3	0,2004	Bethesda,	Maryland
Baltimore, Maryland 21215-0020	permit. Pages of Pepartment of Pepartment of Pepartment: If its any injury or of once.		21. Signature of Funeral Servica Licensee		22, Name and Add				nevy Chase, Inc.
8	Dep Per Per Per Per Per Per Per Per Per Per		istillian R. Kunphr	24. MO1173		sin Avenue,			20814
		$\Box$	23a. Pert1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. I	Do not enter the mode of d	ying, such as cardiac	or respiratory arr	est,	Approximete Interval Between
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	Examiner		resulting in death)	Due to (or as	s a consequence of):				
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	The law requires that the death certificate be assected at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions,	Due to (or as	a consequence of):				
, Ö	e axe ian a urial-	ũ	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c						1
68760,	ate b hysic tha b	Medicai	that initieted events resulting in death) Last	Due to (or as	a consequence of):				
9	ing pt e as t	Me	d						1
Box	eath cer attendir I for use	Physician/							1
	ras that tha der signed by the a be detached f	/sic	Part II. Other significent conditions contribution	ng to death but not resulting	ng in the underlying cause	given in Part I.			e to the cause of death?
P.0	at th d by detac						1 U	/es 2□ No 3□ F	robably 4 Hinknown
S,	signe I be d	by					24a. Was a	an autonsy 24b.	Were autopsy findings
5	w require been si	etec					perfor		available prior to completion of cause
ec	elaw hasb	Completed						-/	of death?
E	The cata pag		7				TOY	•	1 ☐ Yes 2 ☐ No
of Vital Records,	Physician: The rthis cartificata ral director, pag	Be	25. Was case referred to medical examiner?	J:		Whor:	th (Check only or	TOTAL CONTRACTOR OF THE PARTY O	
to	Physic this cral dir	5	1 Yes 2 TNo	1 Inpatient 2 LEH	VOutpatient 3LI DOA	4 Nursing H		enca 6 Other (Specow injury occurred	ecify)
Ē	Ing P	on	1221 tatulal	. Date of Injury (Month, Dey Year)	Injury W	ork? □ Yes 2 □ No	250. 0000.150	,,	
Si	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be 286	Place of Injury - At home	e, farm, street, factory, office		28f. Location (S	Street and Number or F	Rural Route Number,
Division	or At after of Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	5, 121111, 311001, 1201019, 01110		City or Tow	m, Stete)	
ш		ğ	29a. Certifier Certifying Physician:	To the best of my knowle	edge, death occurred at the	time, date and place	, and due to the o	cause(s) and manner a	is stated.
	To the Hospital within 24 hours of the Funeral completaly filled	edicai	(Check only 2 Medical Examiner: O	n the basis of examination nd manner stated.	and/or investigation, in m	y opinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
	o the	N	29b. Signature end title of certifier			ense number		29d. Date signed (Mor	nth, Day, Year)
	F \$ F ŏ	,	100		100	054566		12/28/04	
	1		30. Neme end eddress of person who complet	ed cause of deeth (Item 2)					
	り		Syvi tha Brogavice	1220 A Smit	TODA BOY	d Scash:	230 70	NH UNOZED	21256
	Ç+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	3e) (Type, Print) TOPPO Foc.	1	7	, , , ,	
	Regist		JAN 0 6 2005	The way is	A STATE OF THE PARTY OF THE PAR				

DHMH 16 Rev 6/95

Registrar

Confidence of Death   Discourse Name (Prist, Modes), Last   Discours				State of Ma	ryland / Department of Health and M	lental Hygier	2004 42131
REMINIOR RESIDENCE TO A STATE OF THE PART				Registrar	Certificate of Death		
La Scalar from the control of Dears of Cases of		Physici	an	0 1	Boldwin	Month D	
Security of the property of th							
Special properties   Special		- Zdillill	4	3 ROOSEVELT AVE	Aberdeen	F	Par Ford Ca.
The Company of the Co		Funeral		5. Social Security Number 6. Sex 7. Age	Months Days Hours Min	8. Date of Birth	9. Birthplace (State or Foreign
The control of the country		Director		216-16-4557	Yrs.	11-23-1	425 MD.
The second of th		land ow		10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
The second of th		Mary -f sh	tor	Maryland HAItord Co.	Aberdeen		1 ☐ Yes 2 No
The second of th		or 286	irec		10f. Zip Code	10g. C	
The second of th		235 c	al	3 hoosevelt Ave	21001		U.S.A.
The second of th		tems	nue	Armed Forces?	ver in U.S.  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	
The second of th	36	rs aft	by F	1 Never Married 2 Married 1 Yes 2 No. If Yes, Give 3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White
The second of th	9	2 hou	ted	15. Decedent's Education	16a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of byrop, such as cardiac or respiratory area.  Approximate and Death Marked Call Examiner  Provision Micellical Examiner  The control of the cardiac or respiratory area.  Approximate and Death Marked Call Examiner  Approximate and Death Marked Call Examiner  The control of the cardiac or respiratory area.  Approximate and Death Marked Call Examiner  The control of the cardiac or respiratory area.  Approximate and Death Marked Call Examiner  The control of the cardiac or respiratory area.  The control of the cardiac or respiratory area.  Approximate and Death Marked Call Examiner  The control of the cardiac or respiratory area.  The control of the cardiac or respiratory		hin 7.	ple		life. DO NOT use retired)		narklen
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Provisician (Medical Examiner)  The decidence of the first of the desidence of complete the death. Co not enter the mode of dying, such as cardiac or respiratory arrest. Approximate and the death of t	m	Pe m Pe	y 13	13013	321 S. Philadelp	hia Blud.	Aberdeen, Md. 21001
TO T	п			23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	the death. Do not enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between
Sequentially ist conditions, it and the past 12 months?    Sequentially ist conditions, it and the past 12 months?   1   1   1   1   1   1   1   1   1			) w	disease or condition	ic operative tuling	agres di	Sease Onset and Death
Scausefially list conditions a constitution of the initial decision of the control of the contro				Due to or as a		01 00	
State   Stat			-	Sequentially list conditions, b. De to (or as a	consequence of:	war aus	ease.
State   Stat		petr I Insit	min	cause. Enter Underlying Cause (Disease or injury	San Grandetthurk		
FEMALE:   230. Was deededned pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	Ć,	exection and rial-tra	Еха	resulting in death) Last	consequence of):		
FEMALE:   230. Was deededned pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	192	ite be iysicia ne bur	ical	d	· · · · · · · · · · · · · · · · · · ·		
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9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 24a. Was an and part of part	30	ath ce ttendi or use	lan/	23b. Was decedent pregnant 1 Live birth 2	2 ☐ Fetal death 3 ☐ Ectopic pregnancy		
State		0 0 2	ysic	1 Yes 2 No 4 Pregnant at t	me of death 5 U Other (specify)		,
State	٥.	that the od by detac	/ Ph		t not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
24a. Was an autopsy performed autopsy performe	g,	uires sign ld be				1 Yes	2 No 3 Probably 4 Unknown
State   Stat	00	> 0 0	lete			24a. Was an	24b. Were autopsy findings available
26. Place of Death (Check only one)  27. Manner of Death 1   Yes   2   No  28a. Date of Injury 28b. Time of Injury 3   Suicide 4   Homicide  28a. Date of Injury 4   Yes   Suicide 4   Homicide  28a. Date of Injury 4   Yes   Suicide 4   Homicide  28b. Time of Injury 4   Yes   Suicide 4   Homicide  28c. Injury at Work? 4   Yes   Suicide 4   Homicide  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Clarifier 3   Suicide 4   Homicide  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Date of Injury 4   Yes   Suicide 4   Homicide  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Clarifier 3   Suicide 4   Homicide  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Date of Injury 4   Yes   Suicide 5   Pending investigation 6   Could not be determined  28d. Place of Death (Check only one)  28d. Injury at Work? Mork?	Re	The la te has age 2	ошо			performed	prior to completion of cause of death?
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and an ress of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  22 Accident 3 Suicide 4 Homicide  28f. Location (Street and Number or Rural Route Number, Edity or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f.	ta	an: rtifical tor, p	a		26. Place of Death		10 163 20 140
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and an ress of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  22 Accident 3 Suicide 4 Homicide  28f. Location (Street and Number or Rural Route Number, Edity or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f.	0 [	ng Pt fter th		27. Manner of Death 28a. Date of Injury (Month, Day)		28d. Describe how inj	ury occurred
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Qate signed (Month, Day, Year)  30. Name and a verses of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature	sio	tendi leath. tor: A the fu	catl	2 Accident investigation		206 Leasting (Ctreets	and Numbers as Dural Davids Maria
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Qate signed (Month, Day, Year)  30. Name and a verses of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature  33. Date filed (Month, Day, Year)  34. Date filed (Month, Day, Year)  35. Registrar's Signature	Ĭ	or At after of Direct in by	ertifi	4 Homicide determined 286. Place of injur	. (Specify)	City or Town, Sta	te)
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30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)  30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Mbnth, Day, Year)  32. Registrar's Signature  32. Registrar's Signature		e Hos 124 h 1e Fur iletely	dica	(Check only 2 Medical Examiner: On the basis of	examination and/or investigation, in my opinion, death occurr	red at the time, date ar	nd place, and due to the cause(s)
30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)  30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Mbnth, Day, Year)  32. Registrar's Signature  32. Registrar's Signature		To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
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Dian M. Chenoweth 04-8448 AKG

Physician /Medical Examiner				Cei	rimcate of	'Death'	d Mental Hy	Reg. No.	004	42/32
	III an M. Chanawai h							eath er 30		3. Time of Death 11:10 A
		a. Facility Name (If not institution, give stre 20301 Thunderhead W	et and number)	11	Germant		eath	4c.	County of Death	.y
Funeral Director	3	5. Social Security Number  6. Sex  1 M  Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, D. SEP 9,	ay, Year)		place (State or Fore Intry) Mexico
a-f show		10a. State 10b. County  Maryland Montgome		Town or Lo		ıntown				10d. Inside City Lim 1 ☐ Yes 2 🂢
be filed within 72 hours after death with the Maryland and Hygione.  ad other than "natural", or items 23a or 28a-f show svent, Ite Madical Examiner must be natified at Be Completed by Funeral Director.	Dy Fulletal Dile		urley Boule Was Decedent Ever in U.S Armed Forces? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) If Yes, Give Year or Dates:	. 13.	10f. Zip Code  2087  Was Decedent of If Yes, specify Cut  1 Yes 25 No	Hispanic Origin ban, Mexican, P	? (Specify Yes or No ueno Rican, etc.)	0-	USA 14. Race - Amer Black, White  Specify: Wh	ican Indian,
72 term 14		15. Decedent's Educat (Specify only highest grade of	con completed) College (1-4or 5+) 5 +	(Give life.	dent's Usual Occu kind of work done DO NOT use retire cher	ipation e during most of ed)	working		nd of Business/I	·
12 should be filed within h and Mental Hygiene. 7 is marked other than "I raumatic svent, It a Mark	מ	17. Father's Name <i>(First, Middle, Last)</i> Frank Clermont K				Merd	Name (First, Middle   yth C.	Ponk	0	
permit. Pages 1 and 2 should Department of the fault hand Men Important: If team and single any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, Walter F. Flakus 20a. Method of Disposition  1 □ Burial 2 Ocremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	S / Son  20b. Pla cel	derhea	d Way G Date  5/05 ety of	erma 20c. Lo Ba	ntown, cation-City or 1	MD 208		
rnysician /Medical Examiner	D D	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one climmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	egorchik ions that caused the death. cause on each line.  Amitriptylin  Due to (or as a conseque	Do not en  e Interpretation	99 Fred ter the mode of dy	I <b>C I I C I</b> ring, such as car	<u>Road_Ba</u>	ltim	ore, M	Approximate Interval Betweer Onset and Deatt
icate be executed physician and s the burial-transit	alcai	cause. Enter Undertying Cause (Disease or injury that initiated events c resulting in death) Last  d	Due to (or as a conseque	ence of):						
the attending the dor use a shed for use a windle	ש ו	IF FEMALE: 23b. Was decedent pregnant in the past 12.menths? 1 \sqrt{9} Yes 2 \text{2} No 9 \sqrt{1} Unknown	If yes, outcome of pregnan  1 Live birth 2 Fetal of  4 Pregnant at time of dea  9 Unknown	death 3	□Ectopic pregnand □ Other (specify)	су		2	23d. Date of deli Month	very Day Year
w requires that the been signed by should be detacted by Phrise that the phrine that the phrise that the phrise that the phrise that the phrin		Part II. Other significant conditions contri	outing to death but not resul	ting in the u	nderlying cause g	iven in Part I.		tobacco u Yes 2[		the cause of death
(0)	complet						24a. Was auto perf 1X Yes		24b. Were au prior to deau?? 1 X Yes	topsy findings avail ompletion of cause 2 \( \square\) No
hysician his certifi I director	o De	1832485 2 100		R/Outpatie	K JUDON	ther: 4 🗌 Nursir	Death (Check only  ng Home 5 ☐ Res  28d. Describe	idence .	ther (Spec	ify) at scer
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  Madical Certification: To Be	Certification	1 Natural 5 Pending 2 Accident investigation 3 Significate 6 Could not be determined	Found 29e. Hace of Injury - At hor building, etc. (Specify) Found at home	Injury ne, farm, st	M 10	Yes 2 X	Subjec 28f. Location	t in	ested d	lrug ral Route Number, C <b>hunderhe</b> a
To the Hospital within 24 hours a within 24 hours a To the Funeral I completely filled		29a. Certifier (Check only one) 1 Certifying Physic 2 Medicel Examiner	ien: To the best of my know ": On the basis of examination and manner stated."	rledge, dear on and/or in	h occurred at the vestigation, in my	time, date and p opinion, death o	lace, and due to the	cause(s) date and	and manner as I place, and due	to the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier	ROO-1	~~~ <u>~</u>		.M.E.	;I		e signed <i>(Month</i> lber 31,	
BOLP		30. Name and address of person who compared to the state of the state	bleted cause of death (Item	W 1:		Street,	Baltimore	e, Ma	ryland	21201

		1- State of Mary		artment of H			giene20	04	42133
Dhysia		Decedent's Name (First, Middle, Last)				2. Date of De Month		Year	3. Time of Death
Physic /Medi		Richard W. Eyring, Jr				DECEME	BER 31,	2004	9:27 P M
Examir	ner	4a. Fecility Name (If not institution, give street and number)  1617 SEXTON STREET		4b. City, Town, or	Location of De		4c. County	of Death	
Funeral			yrs. last birthday)	If Under 1 Year	If Under 24 H	rs. 8 Date of Bir	th , ,	9. Birthp	lace (State or Foreign
Director		219-84-5250 10XM 2 F	10 Yrs.	Months Days	Hours M	in. (Month, Da April	13, 1964	Couin Mary	land
and and		Usual Residence of Decedent  10a. State 10b. County 10c	. City, Town or Lo	cation				1	Od. Inside City Limits
Maryl fied a	ğ	Maryland 1	Baltimore	e City					1 ☐Yes 2 ☐ No
th the or 28s	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
ath wi		1617 Sexton Street		2123			United		
Is a yearloo 2 12 12 15 15 15 15 15 15 15 15 15 15 15 15 15	Funeral	11. Marital Status  12. Was Decedent Ever Armed Forces?  1 □ Never Married 2 ☑ Married  1.□ Yes 2 ☑ No	in U.S. 13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		e - Americ k, White,	an Indian, etc.
ours at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify	Wh	ite
72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	urina most of v	vorking	16b. Kind of Bu	siness/Inc	dustry
within ene. than	I I	Elementary/Secondary (0-12) College (1-4or 5+)	Carpe	00 NOT use retired,	)		Constr	notio	an .
filed Hygid other ent,		17. Father's Name (First, Middle, Last)	Carpe	ilcer_	18. Mother's N	lame (First, Middle,			JII
uld be Mental rked ric ev	To Be	Richard William Eyring, Sr.			Judy C	lary			
2 sho and h la ma	ľ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number or	Rural Route Numbe	er. City or Town,	State, Zip	Code)
1 and 1 and 1 ealth 3m 27 ther tr		Rose Halligan/ Sister  20a. Method of Disposition 20	3324 b. Place of Dispo	Oakmeador		_			
portition of the proof of the p			cemetery, crer	natory or other place	) Jan atory 2	uary 6	20c. Location - Odenton		wn, State
nit. P artme ortani injury		. 4 □ Donation . 5 □ Other (Specify)			1				
Depariment of the particular o		Yuter Centr/MO	0969 Re	Name and Address endon Fund 318 East 1	eral Ho Baltimo	me, P.A. re Street	. Balti	more,	MD 21224
		23a. art1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying	g, such as card	iac or respiratory a	rrest,		Approximate Interval Between
Physician	ı	Immediate Cause (Final disease or condition resulting in death)	rgino	1					Onset and Death
/Medical Examiner	ı	Due to (or as a con	isequence of):	1					
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter I had reliable to the cause of the control of the cause of the	nsequence of):						
cuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Couse, closess or injury that initiated events							
cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a con	isequence of):						
icate physics the b	edlcal	d							
onding use a	Ician/Me	IF FEMALE: 23c. If yes, outcome of pr		le			23d. Date	e of delive	гу
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	sicia	in the past 12 months?  1 Ves 2 No  9 Unknown		Ectopic pregnancy Other (specify)			Mor	nth	Day Year
hat the d by ti	Physi	9 Unknown  Part II. Other significant conditions contributing to death but no	requiting in the u	adorhina navas avas	o in Part I	220 Did t	phacen use contr	ihuta ta th	e cause of death?
signe d be	d by	Tan in Case of American Control of the Case of the Cas	rosaming in the di	idenying cause give	miliraiti.	1 🗆 `	10		ably 4 Unknown
law requir as been si 2 should	Completed					24a. Was	an 24b. V	Vere autor	osy findings available
The la	ошь		<del>.</del>			- autor perfo 1 ☐ Yes	osy p rmagol? d	rior to con eath? □ Yes	npletion of cause of
vicien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. Place of C	eath (Check only o	. , ,		2010
Physic this ce al dire	2	18 Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatien		4 LJ Nursing	Home 5 Resid			SCENE
ding F	tion;	27. Manner of Death  1  Natural 5  Pending	(r) 28b. Time of Injury (	28c. Injury Work	? 🗙	28d. Describe	now injury occurre	ed ·	A colf
Attender deatl	fica	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, str		2)2(10	28f. Location	treet and Number	or or Rural	Route Number,
s after safter at Direct	Certification;	4 Homicide determined building, etc. (S)	2000-00-00-00-00-00-00-00-00-00-00-00-00			City or Tov	of alter	750 Gre	xtoxist.
To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical (	29a. Certifier Check only Medical Exeminer: On the basis of example of	knowledge, death nination and/or in	occurred at the tim restigation, in my op	e, date and pla inion, death oc	ice, and due to the curred at the time,	cause(s) and mai date and place, a	nner as sta	ated. the cause(s)
o the ithin 2 o the	Med	one and manner stated 29b. Signature and title of certifier		29c. License			29d. Date signed		
⊢ ≯ ⊢ ŏ		land Hallon	md	0 C	ΜE		JANUARY		
ſλ		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	TATA COMM		T1/07 =		
1 /		CAPOL IT ALLAN M	rd	111 PE	INN STRI	EET, BALT	IMORE, M	1ARYL	AND, 21201
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's S		AL I					
		JAN 0 6 2005 Beauce	47						

			1 - For Amend Items Registrar	State of Manyland 23a per ME, C	Ce	rtificate of L	Death	Re	g. No.	7 1 0 4
W of	Dhysisis		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day # Year	3. Time of Death
	Physicia /Medic		Charles G. Eybel				1			3
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or			Prouve	6-20425
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
Æ,	Director		517-18-7779	M 2□F 8	1 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 29,	1923 Mon	tana
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or L	ocation				10d. Inside City Limits
	Mary - aho	tor	Maryland Prince Geo	orge's Bowi	e					1 X Yes 2 ☐ No
	th the or 28a e.noti	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	ath wi	raic	3118 Teal Lane		1	20715			ISA	dana badian
	itema itema	Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces?	i. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Si n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or flems 23a or 28a-f ahow int, it a Medical Examinat must be notified at	by	3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: 1951 —	53	1 ☐ Yes 2 📉 No	Specify:		Specify: Wh	ite
S O	72 ho natur	Be Completed	15. Decedent's Educ (Specify only highest grade		(Give	edent's Usual Occupa e kind of work done d	luring most of wor	king 1	6b. Kind of Business/	
2	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired,	)			
9 9	filed v Hygie other t	CO	17. Father's Name (First, Middle, Last)	4	Engin	eer	18. Mother's Nan	ne (First, Middle, M	Lerospace Naiden Sumame)	
an	id be lental ked o	To B	C. George Eybel				Astrid	Skretterg	5	
Maryland 21215-0036	2 should and Men is marke sumatic	- -	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mail	ing Address (Street a	and Number or Ru	rai Route Number,	City or Town, State, 2	Zip Code)
	1 and 2 Health em 27		Lee E. Eybel/son	20h Bl	4930	Columbia	Rd. Apt		ia, No 210	744 State
Jor.	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐R	emoval from State		osition (Name of ematory or other place).el Cremato		ember		
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	-0.7					denton, Ma	
a	permit. Departimport Import any inj		Devely L He	Letto moias	/ B	everly L.	Heckrot	on Servic te, P.A.	e P.O. Box Clarksvil	c /84 Le, MD 21029
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death.						Approximate Interval Between Onset and Death
	Pnysician	8 0	Immediate Cause (Final disease or condition resulting in death)	Conde	Eth	ylene Gly	col Inge	stion		Oriset and Death
В	/Medical Examiner	Н	resulting in dealth)	Due to (or as a consequ	ence of):	Respirato	ry Failu	re		
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):	-1				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	the pate	31-/	( Fr. 10	<del>// 9-</del>			
50,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a consequ	ence.of):					
68760	icate be executed physician and s the burial-transit	edicai								
Box (	death certif e attending sd for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnar		□Ectopic pregnancy			23d. Date of de	ivery
	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Other (specify)			Month	Day Year
P.0.	d by the		9 ☐ Unknown  Part II. Other significant conditions con	-	tting in the	underlying cause give	an in Part I	23e Did tob	acco use contribute to	the cause of death?
ds,	law requires that the de as been signed by the a 2 should be detached	d by	Partition significant contained on	middling to douth but not room	and an end	andonying daddo give	or mr urr.	1 <u>□</u> Ye		obably 4 Unknown
COL	w requ	lete						24a. Was ar	24b. Were at	utopsy findings available
Vital Records,	0 - 0	Completed						autopsy perform	ed? death?	completion of cause of
ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	,			26. Place of Dea	ath (Check only one		
of V	S w D	P	Yes 2 No	lospital: 10 Inpatient 2 E		7	4 🗆 Mulsing H		nce 6 Other (Spe	
ono	ding F h. After funera	tion	27. Manner of Death  1 Natural 5 Pending  2 Accident Investigation	28a. D te of Injury (Month, Day Year)	28b. Time of Injury	Work	/at ⟨? Yes 2/⊠No	eta len	w injury occurred I	njested
Division	Attending or death.	fica	Suicide 6 □ Could not be	28e. Place of Injury - At ho	me, farm, s			28f Location (Str	eet and Number or R	ural Route Number,
á	tal or A safter al Dira ed in by	Certification:	Homicide determined	building, etc. (Specify,		ine		Bowie	State) 3118 T	eal Land
	hour mer y fill	edical	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat						
	1 4 T 0		one)	and manner stated.						
	o the Ho ithin 24 o the Fu ompletel	Med	29b. Signature and little of ceptitier	11/1. Ida	Londo	29c. License	e number	29	d. Date signed (Mont	h, Day, Year)
)	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Med	29b. Signature and little of couffier	Il labol for	lister	29c. License	number 72.50		od. Date signed (Mont	
)	To the He within 24 To the F. completel	Med	30. Name and address of person who co	mpleted cause of deat (Item	lists 23a) (Type	Print)	3375	B	Decolos des	
	To the Ho within 24 To the FL Completel	Σ	18/80		pite	Print)	3375		Decolos des	

			1 - For Amend Item 23b State Constant Per	h <b>y</b> ace39d1_6e	artment of Healt	h and Mental	Hygiene	2006 62135
	0		Decedent's Name (First, Middle, Last)			2. Date	of Death	3. Time of Death
	Physicia /Medic Examin	al	Bisbara J. Greca 4a. Facility Name (If not institution, give street and nu	mber)	4b. City, Town, or Locati		mber	29 204 14 15 M
	Examili	er	University of Maryland Medical		Baltimose			N/A
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🗷 F	7. Age (In yrs. last birthda 55 Yrs.		nder 24 Hrs. 8. Date	of Birth h, Day, Year,	Birthplace (State or Foreign Country)
	pu .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			
	Aaryla I shov	ō	36 7 1					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28e-	Director	Maryland Montgomery  10e. Street and Number	Rockvill	10f. Zip Code	-	10g. Ci	tizen of What Country?
	h with 23e or st be		522 Meadow Hall Drive		20851			U.S.A.
	ems 2	Funeral		edent Ever in U.S. 13	3. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specify Yes	or No-	14. Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland had lygiene.  and Hygiene.  and other then "natural", or items 23e or 28e-f show event. The Madred Exacilizations to neither a	by Fu	1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year or D	2 MaNo ve	1 ☐ Yes 2 🗷 No Spec			Specify:
9	2 hour		15. Decedent's Education	16a, Dec	cedent's Usual Occupation		16b. K	White Gind of Business/Industry
215	C 2	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (	(Gi 1-4or 5+)	ve kind of work done during i . DO NOT use retired)	most of working		
2	filed within Hygiene. other then " ent, Ire Mar	Completed	12 5		Teacher			A. County Schools
gue	lbe fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last)			lother's Name (First, N	liddle, Maider	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then surnatic event, the M	2	Joseph B.  19a. Informant's Name/Relationship (Type, Print)	Grzej	ka Je illing Address (Street and Nu	ennie umber or Bural Boute I	lumber City	Bukowski
	rtr		Margaret A. Grey (Sister					Maryland 20851
Baltimore,	ges 1 an of Heal If item 3 or other		20a. Method of Disposition 1 □ Burial 2 【■ Cremation 3 □ Removal from	20b. Place of Dis	position (Name of rematory or other place)	Date		ocation - City or Town, State
Ë	Pag nent int:		*4 ☐ Donation 5 ☐ Other (Specify)	Bayview	Crematory	1/3/05	Balt	imore, Maryland
Bai	Department Page Important: Important: eny injury once.		21. Signature of Funeral Service Licensee		22. Name and Address of Fa McCully-Polyn	acility niak Funera	1 Home	e, P.A.
			23a. Part Enter the disease, or complications that	caused the death. Do not e	3204 mountain	i koad Pasa	dena,	Maryland ZIIZZ Approximate
	Physician		shock, or heart failure. List only one cause on a immediate Cause (Final	,	F :1			Interval Between Onset and Death
	/Medical		resulting in death)	) te Renal (or as a consequence of):	Failure			
	Examiner	ų.		<u>etes Mellitu</u>	s			
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):				
ć	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		that initiated events c. resulting in death) Last Due to	(or as a consequence of):				
8760,	ate be ex hysician he buria	lical	d					
9	death certifica attending pt of for use as t	Med	IF FEMALE:					
Вох	eath c attenc for us	clan	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delivery  Month Day Year
0	at the de by the tached	Physiclan/Med	1 ☐ Yes 2 No 4☐ Pregi 9 ☐ Unknown 9 ☐ Unkn		one (specify)			
s, P	res that igned b	by P	Part II. Other significant conditions contributing to d	leath but not resulting in the	underlying cause given in Pa	art I. 23e.	Did tobacco	use contribute to the cause of death?
ord	w require been si		Metabolic Acidosis				1 Yes 2	No 3 Probably 4 □Unknown
Vital Records,	e law i has bu je 2 sh	Completed	Right Heart Failure			24a.	Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
alF			Diabetes Mellitus			10	res 2 No	
Vit	ysicien: is certific director,	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No Hospital: 1 \sum \text{ Hospital: 1 \sum Yes }  Hospita	Inpatient 2 ER/Outpat	Othors	lace of Death (Check  Nursing Home 5		6 DOther (Constitution
of	를 를 를	-	27. Manner of D ath 28a. Date	of Injury 28b. Time	of 28c. Injury at		ribe how inju	
jor	ttending F death. ctor: After / the funera	atlo	2 Accident investigation	nth, Day Year) Injury	M 1 Yes 2	2 🗆 No		
Division		Certification;	3 Suicide 6 Could not be determined 28e. Place build	e of Injury - At home, farm, ing, etc. (Specify)	street, factory, office	28f. Loca City	tion (Street ar or Town, State	nd Number or Rural Route Number, 9)
	pitel ours a lerel [		29a. Certifier 1 X Certifying Physician: To the	e hest of my knowledge de	ath occurred at the time, date	e and place, and due t	the causele	and manner as stated
	To the Hospitel or within 24 hours afte To the Funerel Dirk completely filled in I	edical	(Check only 2 Medical Exeminer: On the b	pasis of examination and/or iner stated.	investigation, in my opinion,	death occurred at the	time, date an	d place, and due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifler		29c. License numb		29d. Da	te signed (Month, Day, Year)
•	7		L XILLOX	MD	215	899	12	129/04
	La		30. Name and address of person who completed cause	se of death (Item 23a) (Typ		eene s	1	21201
	Sta	ite	31. Date filed (Month, Day, Year) 22. F	Registrar's Signature		ECTIC 2	<b>ST</b>	21261
	Registr		JAN 0 6 2005	was to April	de			

			For State Registrar	State of Maryland	Department of Health and N  Certificate of Death	nental Hygien Reg. N	
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Dealth
	Physicia		Florine C	1 D D D D		Month December	30 2004 10 15 9M
	/Medic Examin		4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Death	-	dc. County of Death
	Examin	er	Sinai Hospital	of Baltime	0 1		N/A
	Europal		5. Social Security Number 6. Sex	7. Age (In yrs. last		8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director			M 20 7 3	Yrs. Months Days Hours Min.	February 21,	Country
	and w		10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits
	dary f sho	ō	10.7	Ba	14 more		1 ₽¥6s 2 No
	the the	Director	10e. Street and Number	34	10f. Zip Code	10g C	Ditizen of What Country?
	with 3a or		2.12	C 1	2 121/4		17CA
	ns 2	era		2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic avant, I'm Medical Erait in at most ke mullifud at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puéric 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Specify: B/9 Ck
ŏ	2 hou	ted	15. Decedent's Educa	ation 1	6a. Decedent's Usual Occupation	. 16b.	Kind of Business/Industry
215	7 nin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ring	
21,	d with	mo:	7+4	Conago (1 40/ 57/	Homemaker		SelF
Þ	othe	Be C	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	en Surname)
<u>a</u>	uld be fenta rkad ric av	To E	Sam Danie	l <	Ma	ncy Das	niels
ar <sub>Z</sub>	should and Mer marks umatic		19a. Informant's Name/Relationship (Typ		9b. Mailing Address (Street and Number or Rui		
	alth a		Name Cleme	nte Barentes	4945 Hopewood L	ant Ch	4.40 NC 28216
<u>6</u>	is 1 a of Hei		20a. Method of Disposition	Aom.		Date 20c.	Location - City or Town, State
Ë	Page ient c nt: If ry or		1 Nation 2 ☐ Cremation 3 ☐ Re 1 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	Stern Cemetern 1/4	1/05 B	altimore MD
Baltimore,	mit.		21. Signature of Funeral Service Licenter		22 Name and Address of Facility	703	
ä	Depa Impo any ir		1 Late		Hant P. Close	Funeral S	Service P.A.
			23a. Part1. Enter the disease, or complic	ations that caused the death. I	On not enter the mode of dying, such as cardiac		Approximate
	Pnysician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen	atic breast can	CEP	
- 8	Examiner			240 (0) 20 2 00/100420/1	55 51,		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter U. 2017/P. Cause (Disease or injury	Due to (or as a consequen	ce of):		
. /	uted d ansit	m.	Cause (Disease or injury that initiated events c.				
~	n an ial-tr	Examiner	resulting in death) Last	Due to (or as a consequen	ce of):		
68760,	Attanding Physician: The law requires that the death certificate be executed rideath. Settlificate has been signed by the attending physician and setor: After this certificate has been signed by the attending physician and y the funeral director, page 2 should be detached for use as the burial-transit	edlcal	d.	_			
_	tifical ig ph as th				- Then		
Box	eath cert attendin for use	n/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de			23d. Date of delivery
	that the death cer ed by the attendir detached for use	by Physician/M	in the past 12 months? 1 □ Yes 2 ■No	4☐ Pregnant at time of death			Month Day Year
P.O.	t the by th ache	hys	9 Unknown	9□ Unknown			
	signed d be det	y P	Part II. Other significant conditions cont	ributing to death but not resultir	g in the underlying cause given in Part I,	23e. Did tobacco	o use contribute to the cause of death?
ĕ	w require been sig should b	pa	typeter sion	)		1 🗆 Yes	2 No 3 Probably 4 ¶Uhknown
တ္မ	s been s shoul	olet	Diabeter M	ellitus .		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Vital Records,	The lay	ompleted				autopsy performed?	death?
tal	ician: Th certificate rector, pag	O	25. Was case referred to medical		26 Place of Deal	th (Check only one)	1  Yes 2  Ne
	s cert	To Be	examiner?	spital: 1 Dimpatient 2 DER	Othor		6 ☐Other (Specify)
of	Phys er this eral di	ΞŢ	27. Manner of Death		b. Time of 28c. Injury at	28d. Describe how in	
on	th. : Afte	tlor	1 Deatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Work? M 1 ☐ Yes 2 ☐ No		
Division of	Attar dea actor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	, farm, street, factory, office		and Number or Rural Route Number,
Ö	al or s after I Dire	Certification;	4  Homicide determined	building, etc. (Specify)		City or Town, Sta	1(0)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C			dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur		
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Day, Year)
	/		) Ollins	000	RES-000	Der	renuber 30 th orri
	1.		30. Name and address of person who con	ppleted cause of death (Item 23		-	timore.
	9		Samarina 4	thmad Mi	). Sinoi Hospital	of Bat	timore.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature			
	Registr	ar	IAN 0 6 2005	Boul & A	ports.		
			07111				

Floring Oreen

Ricardo Jose Graham Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-08346 State of Maryland / Department of Health and Mental Hygiene.

State of Maryland / Department of Health and Mental Hygiene.

State of Maryland / Department of Health and Mental Hygiene.

Registrar Certificate of Death RJ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** KICARDO December 25. 2004 10:45 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Harbor Hospital Center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□F 13-86 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rel', or Items 23e or 28a-f shov Examiner must be natified at 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 6650 a. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel" the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental is marked ARVENS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i mel. 2/2/1 other 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State , crematory or other place, ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department o Important: If eny injury or once. ACMEL CEM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute alcohol intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Be 2 2

Division of Vital Records, P.O. To the Hospitel or Attending Physicien: this After death. within 24 hours after deatl To the Funerel Director: illed in by the

			1 □ Yes 2 □ N	o 3 Probably 4 Unknown
			24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death 1 2 Yes 2 \square No
25. Was case referred to medical		26. Place of Dea	ath (Check only one)	,
examiner? 1 XYes _ 2 \( \) No	miner?		Home 5 Residence 6	Other (Specify)
27. Manner of Death  1 Natural 5 Pendir 2 Accident investig	gation 12-25-04	Ink 28c. Injury at Work? M 1 □ Yes 2 No	28d. Describe how injury oc	curred <b>unk</b>
3 🗍 Suicide 6 🖍 Could 4 🗍 Homicide determ		et, factory, office	28f. Location (Street and No. City or Town, State) 3 Baltimore. MD	514 Round Rd.,
29a Certifier 1 ☐ Certifyin	ng Physician: To the best of my knowledge, death	occurred at the time, date and place	e, and due to the cause(s) and	I manner as stated.

29b. Signat of certifier

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Year

**OCME** December 26, 2004

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Certification:

Medical

			State of Maryland / Department of Health and Me	ental Hy	giene	
			1- State Registre AMEND ITEM #20b PER FH C839 CAST Gate of Death	- F	Reg. NO	1.2120
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		BETTY DEAN HARRIS	12	31 2004	2149 "
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	0	4c. County of Death	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		b 9 Birth	place (State or Foreign
н	Funeral Director		214-18-2518 10 M 2 SF 48 Yrs. Months Days Hours Min.	8. Date of Birt (Month, Day	y Year) Cou	intry)
		Ī	Usual Residence of Decedent	July a	1,1150,111	TY ZITIOIS
	rylan		10a. State 10b. County 10c. City, Town or Location	d		10d. Inside City Limits
	e Ma 3e-f e	cto	MARYLAND N/A BALTIMORE	617	ry	1,⊠Yes 2 □ No
	ith th	Dire	10e. Street and Number	7	10. Citizen of What Cou	intry?
	s 238	Funeral Director	1108 N. MOUNT ST. APTB 2121	/	USA	iona ladina
	item item	un.	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sperifice) If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	- 14. Race - Amer Black, White	
336	ar, or	by F			Specify:	ACV
5-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f ehow saftal Examiliar mat be malified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin		16b. Kind of Business/I	ndustry
2	within 7 ene. then "r	nple	Elementary/Secondary (0-12) College (1-4or 5+)	'g		
21	filed wi Hygien other th	Cor	8 HIGRADE SECURITY GUAR	Δ.		TAS
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other then aumatic event. It e M.	Be		(First, Middle,	* 3	
N N	hould d Mer mark maric	ို	19a. Informant's N. Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	I Pouto Numbe		RIS in Coda
Ma	id 2 sh ith and 27 le m traum			APT B	B D TOWN, State, 2	2.21217
ē,	1 ar Hea em 3		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or 1	
Baltimore	Pages nent of int: If it		1   Burial 2 A Cremation 3   Removal from State  4   Donation 5   Other (Specify)	8-45	BATHA	0= 11 h
ij	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee 22. Name and Address of Facility &	2000	TO FUNE	RAL Home
ä	Deparent Dep		Lietich N. William 2140 N. FULTON	AVE. 2	BALTO. MD	.21217
1	H - H		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition CV A			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			3
	Examiner	L	Sequentially list conditions, b.			
_	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Jacobs or Irijus)			
	xecut and al-trar	xan	that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dlcal	d			
.89	ificati g phy as the					
Вох	n cert andin use	M/III	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of dela	,
	deat death	by Physician/Me	in the past 12 months?  1  Yes 2 No 9 Unknown		Month	Day Year
P.0	at the 1 by th stach	Phy	9 Unknown 9 Unknown			
	requires that the death certifi een signed by the attending hould be detached for use as				obacco use contribute to res 2 □ No 3 🕱 Pro	the cause of death?
Records,	w requir been si should	Completed		-		
Sec.	e law has b	nple		24a. Was	an 24b. Were aut prior to c rmed? death?	opsy findings available ompletion of cause of
E F	ate pag			1 ☐ Yes	2 No 1 ☐ Yes	2 No
Vita	Physician: The lar this certificate has ral director, page 2	Be	25. Was case referred to medical administration 26. Place of Death Hospital: 1 Minopital: 2 IFP/Outpationt 2 IFF/Outpationt 2			
of Vital	Phys r this ral di	7	1 A inpatient 2 ENOutpatient 3 DOA 4 Nursing Hom		dence 6 Other (Spec	ify)
O	ding th: : Afte	tlor	27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Accident investigation  28c. Injury at Work? 1 Yes 2 No			
Division	Atter r dea ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Number or Ru	ral Route Number.
Ö	tal or Attending Physiss after death. sal Director: After this coed in by the funeral dire	Certification:	4 Homicide building, etc. (Specify)	City or Tow	m, State)	
	hour uner	cal	29a. Certifier (Check only (Ch			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Medical	one) and manner stated.			``
	To With	<	3 2 0 0 1		29d. Date signed (Month	
	$\cap$				12-31-2	OCH
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	RALT	impire no	21218
	Sta	te	31. Date filed MANY Day, Good 005 32. Registrar's Shrature	, 0.1.	1,1101-0,110	
	Registr		JAN V V ZOUS JAN			

1 - For State Registrar

10a State

**Physician** 

/Medical

**Examiner** 

Director

by Funeral

Completed

**Funeral** 

Director

Is marked other then "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Exercises must be notified at

Hygiene.

2 should be finance and Mental H

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30, 2004 4c. County of Death December Name (If not institution, give street as 4b. City, Town, or Location of Death Age (In yrs. last birthday) Days 1 MM 2□ F Yrs. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced 'nI 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry ing most of working Elementary/Secondary (0-12) College (1-4or 5+) E INSTAILER Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GENBURNEMD ZLOGI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State BAYVIEW CAEMATORY \* 4 ☐ Donation 5 ☐ pther (Specify) 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Squamous disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy 4□Pregnant at time of death Month Day Year 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

the attending physician

ğ

certificate

After this

Diractor:

Box 68760

P.O. |

Division of Vital Records.

To the Hospital or Attending Physicien:

hours after death.

24 hours a

To the

Medical

parmit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny injury or other trau once.

Examiner burial-transit Physician/Medical the use as jo by 99 page 2 should Completed 2 Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

1 Yes 2 No 3 Probably 4 Winknown

24a. Was an autopsy perform 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death Check on one spital: 1 Inpatient 2 28a. Da'e of Injury (Month, Day Year) Other: 2 ER/Outpatient 3□ DOA

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 🗌 Yes 27. Manner of Death 1 Natural 2 Accident 5 Pending

25. Was case referred to medical examiner?

investigation 6 Could not be determined 28h Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Hen

D627415

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North Arundel Hospital, Glen Bunnic, MD MU 32. Registrar's Signature

			For State Registrar	State of Ma	ıryland		artment					giene 100 2 0 0 4	42140	
			Decedent's Name (First, Middle, Last)	- //	,						2. Date of Dea Month		3. Time of Death	
	Physicia /Medic	al	Margaret		hon	ann					Decembe	er 29, 2004	4 7:30P M	
	Examin	er	4a. Facility Name (If not institution, give str				4b. City,		Location of	of Death		4c. County of Dea		
	Funeral		Doctors Communi 5. Social Security Number 6. Sex		(In yrs. la.	st birthday)	If Under	1 Year	ham If Under		8. Date of Birth	Prince Georges  o of Birth inth, Day, Year)  9. Birthplace (State or Foreign Country)		
	Director		577-44-2420	/I 21⊠ F	93	Yrs.	ay) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 27, 1911 Washington						hington DC	
	and		Usual Residence of Decedent  10a, State 10b, County		10c. City,	Town or Lo	cation						10d. Inside City Limits	
	Maryl -f sho	ţō	MD Prince Ge	orges		New (	Carro	11to	n				1,CXYes 2 □ No	
	th the or 28a	Director	10e. Street and Number		-		10f. Zip	Code				log. Citizen of What C	ountry?	
	ath wi	ralD	8500 Oglethorpe					207				U.S.A.		
	ltems	Funeral	11. Marital Status  1 Never Married 2 Married	Nas Decedent E Armed Forces? 1 ☐ Yes 2 K N		. 13. \	Was Deced f Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
920	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show after Examiliter must be multified at	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	0		1 ☐ Yes 2	No 🏝	Specify:			Specify: W	nite	
2-0	n 72 hours after death with the Marylar "naturel", or Items 23a or 28a-f show offeel Exacultur in set be rediffed at	Completed	15. Decedent's Educa (Specify only highest grade			16a. Deced	dent's Usua kind of wor DO NOT us	i Occupa	ition luring mosi	t of worki	na	16b. Kind of Business	s/Industry	
121	within ene. then "	dm	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	0 <i>0 NOT</i> us H <b>ome</b>					Private	2	
d 2	filed Hygi other	a	17. Father's Name (First, Middle, Last)							er's Name	(First, Middle,	Maiden Sumame)		
ılan	should be nd Mental marked c	To B	James Ferrier							Josep	hine Gr	ay		
Maryland 21215-0036	C1 00 00 00		19a. Informant's Name/Relationship (Type			19b. Mailin	g Address	(Street a	nd Numbe	er or Rura	l Route Numbe	r, City or Town, State,	Zip Code)	
	1 and Health tem 27		Dorothy Stinnett- 20a. Method of Disposition	Daughter			Raint				anford	KY 40484 20c. Location - City of	Town State	
nor	8°= 2		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	moval from State	1	ice of Dispo metery, cren Linc				1/4	/2005	Brentwood		
Baltimore,	permit. Pa Departmen Important: any njury		21. Signature of Funeral Savide Licensee			22	. Name an	d Addres	s of Facilit	For	Linco	ln Funeral twood MD 20	Home	
	- 4		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused	the death.								Approximate Interval Between	
Щ	Pnysician		Immediate Cause (Final disease or condition	Cong	esti	re H	ear 1	L	وزاره	re			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or all a	conseque	ence of):	CD		time				1 16	
	ŝ	ē	Sequentially list conditions, it any, leading to immediate	Due to (or as a	s-conseque	ence of):	88.00	-					77.047	
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8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Hyper	conseque	ence of):	and	, <sub>W</sub> ,	rberl	122	densa		Mary Mas	
687	ficate I physi s the k	edical	d.	1177	,			-//	,,,,,,				1 1447 913	
Box.	ne death certificate the attending phys hed for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of the complete of the comp	2 🗌 Fetal c	death 3□	Ectopic pro Other (sp.					23d. Date of de Month	olivery Day Year	
P.O.	faw requires that the d as been signed by the 2 should be detached		Part II. Other significant conditions conti	ibuting to death bu	ıt not result	ting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use contribute t	o the cause of death?	
Vital Records,	w requires been signe should be	ompleted by	Rectal Carcina	ma in	20	01,					1 🗆 Y	es 2 No 3 P	robably 4 Unknown	
eco	e taw re has bei	plet	Colon Carcino	ma 19	98	Deep	· le	100	25		24a. Was a	an 24b. Were a	utopsy findings available completion of cause of	
E R	Thate ate	Con	Thrombosis	1 199	8, 0	oste	000	~05	i's		perfor 1 Tes	med? death? 2 No 1 Yes	s 2 No	
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	spital:	,			. Othe			(Check only or			
o	y Phys er this eral di	$\vdash$	27. Manner of Death	28a. Date of Injur	y   2	28b. Time of		8c. Injury Work				ence 6 Other (Spe	əcify)	
ion	Attending Is death. sctor: After by the funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury	М		/es 2 □	No				
Division	or Attendater deatl	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc			eet, factory	, office		1	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,	
	Hospital	edical Ce	29a. Certifier 1 ☐ Certifying Physi (Check only one) 2 ☐ Medical Examine	cian: To the best of er: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred vestigation,	at the tim	e, date an pinion, dea	d place, a	and due to the co	ause(s) and manner a late and place, and du	s stated. e to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of pertifier	. 1	_				number		2	29d. Date signed (Mon	/	
			fit /	7 M	-			D 3	100	· t		12/30	104	
	0		30. Name and address of person who con	pleted cause of de	eath (Item :	23а) (Туре,	Print) 7 5	100	en	be i	ray Ca	D 2077	re, #430	
2	Sta Registr		JAN 0 6 200	32. Hagistra	ar's Signatu	lie en	house	,						

			For State Registrar	State of Maryland /	Department of H		ental Hygier	4004	42141
	Physicia	an	1. Decedent's Name (First, Middle, Las	HART			2. Date of Death Month	ay Year	3. Time of Death
	/Medic		4a Facility Name (If not institution, give		4b. City. Town, or	Location of Death	ecember.	1c. County of Death	0,0511
H	Examin	er	Franklin Sava	1 1:0 11	Rosed	1 1 -		Baltimo	1P
	Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. last bi	irthday) If Under 1 Year		B. Date of Birth (Month, Day, Yea		ace (State or Foreign
	Director		243-09-5923 /	20F 87	Yrs.	A	PRIL 16,10	917	"NC
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	wn or Location			10	d. Inside City Limits
	Mary I eh	to	MD BAL	TIMORE	CARNEL	-1			1 ☐ Yes 2 ☑ No
	th the or 288 e noti	irec	10e. Street and Number		10f. Zip Code	-	10g. (	Citizen of What Count	ry?
	23e (23e (23e (23e (23e (23e (23e (23e (	Funeral Director	3009 4Th	Ave		1234		U.S.	
	er de:	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - America Black, White, e	
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene.  In Marked other then "naturel", or items 23e or 28e-f ehow marked other then "naturel", or items 23e or 28e-f ehow imatic event, the Movical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married  2 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ M0 If Yes, Give Year or Dates:	1□ Yes 2□ No	Specify:		Specify: Luh	TE
21215-0036	72 hou	Completed	15. Decedent's Ed (Specify only highest gra		a. Decedent's Usual Occup (Give kind of work done of	ation	16b.	Kind of Business/Ind	ustry
21	ithin 7 ne.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1)			Pares
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)	142	PRINTER	18. Mother's Name (		OMMERCIAL	Press
Maryland	should be filed withic nd Mental Hygiene. marked other then imatic event, Ibe M.	) Be					T. MUL		
Ž	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (	YAR ( Type, Print) 19	b. Mailing Address (Street				Code)
	nd 2: alth ar 27 ie 27 ie		EVELYN CO	mer	3009 4th	Ave Bo	Ito. his	21234	
altimore,	of Hear of Hear fitem r othe		20a, Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	of Disposition (Name of ery, crematory or other place	Da	te 20c.	Location - City or Tov	vn, State
Ĕ	Pages ment of 1 ent: If its ury or o		*4 ☐ Donation 5 ☐ Other (Specify	V) PARK	wood Cemete		05 3	oute MD.	
Balt	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 ie marked any injury or other treumatic ev 2006.		21. Signature of Funeral Service Licen	Stell	22. Name and Address HARTICH MI	ss of Facility S Te ller FD B	Un Fune	21134	CH7),
1	4		23a. Pa 1. Enter the disease, or company shock, or heart failure. List only	plications that caused the death. Do	not enter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. C.O.P.D	Exacerb.	ation			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):				
	3	-e	Sequentially list conditions, if any, leading to immediate	b	e of):				
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C					
oʻ	ate be executed nysician and he burial-transit	Еха	resulting in death) Last	Due to (or as a consequence	e of):				
8760,	death certificate be executed e attending physician and od for use as the burial-transit	licai		_ d			<del></del>		
9	death certificat attending phy d for use as th	/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			-	22d Pate of deliver	
Вох	eath c attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal deat	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of deliver Month	y Day Year
oʻ.	the d by the ached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	_ , , , , , , , , , , , , , , , , , , ,				
S, D	The faw requires that the deate has been signed by the apage 2 should be detached f	by Pi	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ıd	w require been sig should b						1 Des	2 No 3 Proba	ably 4 □Unknown
Record	has be	Completed					24a. Was an autopsy	prior to com	sy findings available apletion of cause of
<u> </u>	The cate h	Con					performed		2 □ No
Vita	Physicien: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	Oth Oth	26. Place of Death			
ot	Phyer this ral dir	-: To	1 ☐ Yes 2 ☑ No 27. Man or of Death	28a. Date of Injury 28b.	Outpatient 3 DOA  Time of 28c. Injury Wor	4   Indising Hom	<ul> <li>5 ☐ Residence</li> <li>3d. Describe how in</li> </ul>	6 ☐ Other (Specify, ijury occurred	)
o	Attending or death. ector: After by the fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) n		k? Yes 2 □ No			
Division of Vital	Attendi er death. ector: A by the fu	ifice	3 ☐ Suicide 6 ☐ Could not b		farm, street, factory, office	28	Bf. Location (Street City or Town, St.	and Number or Rural	Route Number,
ā	tel or A rs after el Direc ed in by	Certification:	Tionicia	building, ste. (aposity)					
	To the Hospitel or Attending Phyeicien: The t within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical		nysician: To the best of my knowled; ninar: On the basis of examination a and manner stated.					
	To th withir To th comp	M	29b. Signature and title of certifier	W.	29c. Licens			Date signed (Month, L	
)	/		July ol.	Mumo		56477	10	7-31-C	9
	Ŋ		30. Name and address of person who	completed cause of death (Nem 23a	(Type, Print)	Λ	. 1 .		
		9	31. Date filed (Month, Day, Year)	nger 9000 Fra	nklin Sguare	e Drive B	altimore	mo, 212	331
**	Sta Regist		JAN 0 6 200	Mi .	Corelle				
			47.11. V = 4.00	W BARRETON TO S	California March				

			State of Maryland / De 1- State of Maryland / De	partment of Health Certificate of Death	_	giene 004 42142			
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Dea Month				
	Physicia /Medic		Barry Lynn Iverson		DECEMP	Elic 30 Just 8.33 p M			
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location  Lanh		4c. County of Death			
			Doctors Community  5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	ay) If Under 1 Year If Unde	er 24 Hrs. 8. Date of Birth	Prince Georges  9. Birthplace (State or Foreign Country)			
ı	Funeral Director		578-52-7813 1⊠M 2□F 62 Yrs	Months Days Hours	June 22	Country) 2, 1942 Washington DC			
	pu *	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits			
	Manyla f sho			ashington DC		1√ Yes 2 No			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event. It is Madical Erain are must be inclined at anone.	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?			
		al D	1313 I Street NE	20002		U.S.A.			
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic O If Yes, specify Cuban, Mexica</li> </ol>	Origin? (Specify Yes or No- an, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.			
36	s afte	by Fu	1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No 1960 — If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1964	1 ☐ Yes 2 A No Specify		Specify: Black			
Maryland 21215-0036	tural	ed t		acedent's Usual Occupation		16b. Kind of Business/Industry			
215	hin 72	plet	(Specify only highest grade completed) (Give kind of work done during most of worki						
2	ed wit	To Be Completed	12	Postal Officer		Government			
and and	be fill htal H ed off		17. Father's Name (First, Middle, Last)  Arthur Heralou		her's Name (First, Middle, Ella Ashton	Maiden Sumame)			
<u>=</u>	hould Mer marke			r, City or Town, State, Zip Code)					
	nd 2 s lith ar 27 is r treu			13 I Street NE					
Jre,	as 1 a of Hez Item	1	20a. Method of Disposition 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State	sposition (Name of crematory or other place)	Date	20c. Location - City or Town, State			
Ĕ	Page ment ant: if ury or		1 □ Burial 2 Scremation 3 □ Permoval from State 1 □ Donation 5 □ Other (Specify) Fort Li	ncoln Cremator	the state of the s	Brentwood, MD			
Baltimore,	permit. Depart Import any inj once.		21. Signature of Funeral Sector Licensee			n Funeral Home			
	402 e d		23a. Part1. Enter the disease, or complications that caused the death. Do not			rest. Approximate			
			shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death			
	Pnysician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of)	trisio my of	nainy	years			
	Examiner		Samuellally let anothing	rotic Candi	ovascular i	Disease Years			
	P #	Iner	if any, leading to immediate Due to (or as a consequence of)						
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)						
760,	sician buria	calE							
89	ifficate g phy as the		J						
Box	th cer tendin r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year			
Б	the att	sici	in the past 12 months?  1  Yes 2  No 9  Unknown  1  Ves 2  No 9  Unknown	5 Other (specify)		Worth Day Feat			
₾.	es that the death certifica igned by the attending ph be detached for use as th	, Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part	t I, 23e. Did to	bacco use contribute to the cause of death?			
ds,	uires signe	d by	Resnivatory Failure	Yes 2 No 3 Probably 4 Unknown					
Ö	The law requires that the death certifics ate has been signed by the attending propage 2 should be detached for use as It	olete	Diagety mellitus		24a. Was a	an 24b. Were autopsy findings available			
Re		Completed by			autop:	sy prior to completion of cause of death? 2 ☑ No 1 ☐ Yes 2 ☐ No			
Vital Record	sien: artifica ctor, p	Be C	25. Was case referred to medical examiner?		ce of Death (Check only or				
> <	Physicien: r this certifica ral director, p	ဥ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp		Nursing Home 5 Resid				
n c	Jing P	:lon:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28b. Tirr (Month, Day Year)			ow injury occurred			
Division of	Attending it death. ector: Atterby the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm		28f. Location (Street and Number or Rural Route Number,				
<u>S</u>	el or / s after si Dire	Certi	4 Homicide building, etc. (Specify)		City or Tow	мп, State)			
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	7	29d. Date signed (Month, Day, Year)			
)			Danllen Work how	D018	5 2 1	DECEMBER 31, 2004			
1	n		30 Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	HyaTISUI	DECEMBER 31, 2004 (le MI) 20781			
l	Sta	ite	31. Date filed (Month, Day, Year)  32. Pgistrar's Signature	10031144100	,				
	Regist		JAN 0 6 2005 Steen &	and .					
DH	MH 17 Rev 1/2	001	The second secon	No.					

			1 - For State Registrar	State of M			t of Health a e of Death	and Mental H	Hygiene Reg. No. 2	004	42143
	Physici /Medic	an al	1. Decedent's Name (First, Middle Joseph Philli		3			2. Date of Month Decen	Day	Yeer 2004	3. Time of Death 2:20A M
-	Examin		4a. Facility Name (If not institution, Millennium @	South Riv	/er	Edg	Town, or Location  Water  1 Year   If Under		Ann	onty of Death	
	Funeral Director		5. Social Security Number  577-46-3611  Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birth 45 Y	Months	Days Hours	Min. June	Birth Day, Year) 30 195	9 Mary	ace (State or Foreign fry) yland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avent, I've Medical Experiment must be multiled at once.	ector	10a. State 10b. County Maryland Anne  10e. Street and Number	Arundel	10c. City, Town Sever	na Par			10a Cisinan	of What Count	0d. Inside City Limits 1X Yes 2 □ No
		Funeral Director	134 S. Jennings Rd.			211	21146			USA	
920		þ	11. Marital Status  ↑ Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces of Types 2 Date of Types 2 Dates	? [No	13. Was Deced If Yes, spec		igin? (Specify Yes or n, Puerto Rican, etc.)		Race - America Black, White, e ecity: Blac	etc.
21215-0036		Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	College (1-4o	(	Decedent's Usua Give kind of wo life. DO NOT us Design	rk done during mos se retired)	st of working		er Business/Ind	
Maryland 2		Be	12th 17. Father's Name (First, Middle, I Joseph Edward	Kirkland		pesign	18. Moth	er's Name <i>(First, Mid</i> 1is Cunn	ldle, Maiden Sun	name)	, Cu
nore, Mary	ages 1 and 2 sho int of Health and 1 t: If itam 27 is mu y or other trauma		19a. Informant's Name/Relationsh  Margurite Kirl  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)	x1and(Moth 3 □Removal from Stat	ner) 134 20b. Place of l ASBULLY	S. Je Disposition (Nar crematory or o	ennings	er or Rural Route Nu Rd. Seve Date -5-05	rna Pa 20c. Locatio	rk, Mo	d. 21146
Baltimore,	permit. P Departme Importan any injur.		21. Signature of Funeral Service I	icensee	0483	rch 22. Name ar Wm - Re 821 We	d Address of Facilities & Stephenson	ons Mort Annapoli	uary,	P.A. 2140	1
	The law requires that the death certificate be executed WENT Cate has been signed by the attending physician and Union proper should be detached for use as the burial-transit	icai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	s a consequence of	i): '):	e of dying, such as	cardiac or respirator	y arrest.		Approximate Interval Between Onset and Death
. Box 68		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  Fetal death at time of death	3 □Ectopic pi 5 □ Other (sp			23d.	Date of deliver Month	y Day Year
		ρ	Part II. Dther significant condition	ns contributing to death	but not resulting in	the underlying o	ause given in Part		id tobacco use o		e cause of death?
ď		Completed	(alli	e 10 i	Wille				utopsy erformed?	prior to com death?	sy findings available apletion of cause of
Vits	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №	Hospital:	tiont 2 EP/Out	nationt 3 0	Othor	e of Death (Check or		Other (Specific	
	To the Hospital or Attanding Phys within 24 hours after death.  To the Funaral Director: After this of completely filled in by the funeral directors.	-	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28c. Injury at Work?							
Divis		Certification:	4   Homicide	Id not be permined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28		City or	8f. Location (Street and Number or Rural Route Number, City or Town, State)				
		edical	(Check only one) 2 Medical	exeminer: On the basis and manner	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					the cause(s)	
	With To To	×	29b. Signature and title of certifier			290	. License number	376		gned (Month, D	Jay, Year)
	2		30. Name and address of person	who completed cause of	death (Item 23a) (1	ype, Print)	או פע	528	11-3	-05	
	Sta Registi		31. Date filed (Month, Day, Year)	2005 2005	trar's Signature	gely A	ive.Ste.2	3) Anna	polis, r	ND.Z	140

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 3:30 pm **Physician** December 28 2004 5 Que /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign Days 1 M 2 F MARYL Hours 200 -76-4806 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 124 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 5 Completed by 3 Widowed 4 □ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ೭ 2 N KNOWK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAGTERSTOWN, MD KAUPH LATTISAW 21740 20b. Place of disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature Fune al Pervice License 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each in Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) NCC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ 110 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) ONS Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 Ø Other (Specify) 1+0 vv-28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner The law requires that the death certificete be executed

**Funeral** 

Director

Show

r then "netural", or items 23a or 28a-f sho The Medical Examiner roust be notified at

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Jet, Maryla
Jemit. Pages 1 end 2 should be 1
Department of Health and Mr
Important: If item 27 \*\*
any Injury or \*\*\*

ettending physiclen end I for use as the buriel-transit

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Certification: To

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner Be Completed by

Medical State

To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.

Registrar

5 Pending investigation

6 Could not be determined

29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes

2 🗆 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

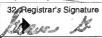
acation h

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and address of person who completed cause of death (Item 23a) (Type, Print) ASSIT 11110

31. Date filed (Month, Day, Year) JAN 0 6 2005

deris



			State of Maryland / Dep.	artment of Health and Me	•	_	
		1 - For State Registrar	-	rtificate of Death	Reg.	2006	42145
Physic	cian	1. Decedent's Name (First, Middle, Las			2. Date of Death Month	Day Year	3. Time of Death 2:45 P.M.
/Med	ical	Kenneth Eugene La  4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	December	3) 2004 4c. County of Death	
Exam	mer	North Arundel Hos		Glen Burnie		Anne Arun	
Funera		Social Security Number 6. S	ex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 6 Months Days Hours Min.	B. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
Directo	r	Usual Residence of Decedent	X <sup>M</sup> <sup>2</sup> □ <sup>P</sup> 73 Yrs.		03/26/19	31	MD
ryland		10a. State 10b. County	10c. City, Town or Le	ocation			10d. Inside City Limits
FOR HARD LIST LAW APPROVE AND AND LIST STORE, Maryland 21215-0036  1096 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  18 itsm 27 is marked other than "natural", or Itams 23a or 28a-1 show or other traumatic event, the Medical Examinat must be notified at	Director	MD Anne Aru	indel Glen Burn		····		1 ☐ Yes 2 XNo
with II	D I	1211 Branch Lane		10f. Zīp Code 21061	10g.	Citizen of What Cou	intry?
death death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	USA 14. Race - Amer	
36 after	y Fur	1 ☐ Never Married 2 ☒ Married	1 ⊠Yes 2 □ No 1951 —	1 Yes 2 No Specify:	can, etc.)	Black, White	
21215-0036 ad within 72 hours at giene. er than "natural; or er than "natural; or, the Medical Exam.	ed by	3 Widowed 4 Divorced	Year or Dates: 1955	dent's Usual Occupation	166	b. Kind of Business/li	
215 215 hin 72 an "na Media	Completed	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)	de completed) (Give life.	kind of work done during most of working DO NOT use retired)	7	. Italia of Education	ioustry
21, the	Con	12	1 Shee	t Metal Worker		S Coastga	urd
and 1be fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last) George Washington		18. Mother's Name (		den Sumame)	
should Me mark	To	19a. Informant's Name/Relationship (7		Emma Lou		ity or Town, State, Zi	p Code)
Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n, any injury or other traument event, the Medi	1	Mrs. Catherine La	Mar / Wife 1211	Branch Lane Glen B	urnie, M	d 21061	
Ore of He of He or othy		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	20b. Place of Dispo	osition (Name of Da matory or other place)		. Location - City or T	own, State
transition of plants		*4 □ Donation 5 □ Other (Specify	) Cheasape	ake Cremation 01/07		evensvill	
Bal Depa Impo		21. Signature of Funeral Service Licen	2000111111111111	2. Name and Address of Facility Sin Second Ave. SW, G1	-		me, PA 061
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do not en				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	· metartatic 1	me concer			Onset and Death
/Medica Examine		resulting in death)	Due to (or as a consequence of):	0			
		Sequentially list conditions, if any, leading to immediate	b. Due to (odas a consequence of):				
outed out	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.				
760, te be executed ysician and		resulting in death) Last	Due to (or as a consequence of):				
876 icate b	dical	•	d				
Box 687 leath certificate attending phys	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	rery
O. B. ie death the atte	Physiclan/Medl	in the past 12 months? 1 ☐ Yes 2 ☐ No		□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O. that the do by the detached	Phy	9 Unknown	ontributing to death but not resulting in the u	underhine eques ques in Part I	23e Did tobac	co use contribute to	the cause of death?
Division of Vital Records, P.O. or Attending Physician: The law requires that the datter death.  Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached	d by	atti, otto significant conditions of	orthodring to death but not resutting in the t	alloonying cause given in Parti.	1X es		bably 4 Unknown
Cord  Iw require s been si	lete				24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Rec	Completed				autopsy performed	l? death?	ompletion of cause of
f Vital Roysician: The is certificate had director, page	Be	25. Was case reterred to medical examiner?		26. Place of Death (	/ /		1
of N Physi this o	2	1 Yes 2 No 27. Manner of Death	Hospital: Inpatient 2 ER/Outpatien  28a. Date of Injury 28b. Time of		d. Describe how i	e 6 Other (Speci	fy)
ion oding lath.	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		.,,.,,	
ivisio	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
Dital o							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my knowledge, deat niner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an evestigation, in my opinion, death occurred	d due to the cause I at the time, date	e(s) and manner as a and place, and due t	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,	Day, Year)
		Asolo	MD	1) 43977	De	Centrer	31 2004
15		30. Name and ad vess of person who	completed cause of death (Item 23a) (Type,	Print)	200	Cember.	
S	tate	31. Date filed (Month, Day, Year)	32. Jegistrar's Signature	with swhie	- / -		
Regis	trar	JAN U b 2	1000 Japanes de 1	200			

		1 - For State Registrar		Maryland / Dep		Health a	-	_	04	42146
		Decedent's Name (First, Middle,	Last)		Timodio or	Douin	2. Date of I		-	3. Time of Death
Physic /Med		BURT STEVEN MUR	ZYNSKI				Month 12	Day 31 2	Year 2004	11:04P M
Exam		4a. Facility Name (If not institution,		er)	4b. City, Town, o	or Location of	Death	4c. County		
		641 RIVERSIDE D	RIVE		PASADEN			ANNE	ARUND	EL
Funera			i.Sex 7 X□M 2□F	Age (In yrs. last birthda)	Months Days	If Under 2 Hours	Min. (Month, I	Day, Year)	9. Birthp Coun	lece (State or Foreign try)
Directo	r 	270-18-5911 Usual Residence of Decedent	7.5	88 Yrs.			05/10	0/1916		OH
/land		10a. State 10b. County		10c. City, Town or I	ocation				10	0d. Inside City Limits
Man.	ţ	MD ANNE AR	UNDEL	PASADENA						1 ☐ Yes 2 🛣 No
th the or 28;	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
ath wi		641 RIVERSIDE D	RIVE		21122	2		USA		
er deg	Funerai	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13	. Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No- 14. Rad Bla	ce - Americ	
36 rs afte	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 [X]Yes 2 [ If Yes, Give Year or Date:	□No 1941- s: 1945	1 ☐ Yes 2 🗓 No	Specify:		Specif	ν: WHI	TE
P hou	ed	15. Decedent's		16a, Dec	edent's Usual Occup	pation		16b. Kind of B	lusiness/Inc	lustry
21215-0036 d within 72 hours after death with the Maryland glene. glene than "natural; or Items 23s or 28s-f show at than "natural; or Items 23s or 28s-f show the motified at	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	(Giv	e kind of work done DO NOT use retire	during most	of working			,
d 21, filled wit Hygiene the there the	Con	11	35(1.15		VER			DELIV	/ERY	
and 2 be filed that Hygi	Be	17. Father's Name (First, Middle, La					's Name (First, Midd		тө)	
Via nould Men warks	2	STANLEY MURZYN					J 22 22 17 17 17 17 17 17 17 17 17 17 17 17 17	RGA		
Maryland d 2 should be file th and Mental Hy 27 is merked oth treumetic event		19a. Informant's Name/Relationship MS. JANE MICLAY					or Rural Route Num		, State, Zip 21122	Code)
Te, N 1 and Health tem 27	1	20a. Method of Disposition	/ DAUGHTER		osition (Name of amatory or other pla		Date	20c. Location		wn. State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		10	ematory or other pla CEMETERY		/06/2005	TOLEDO,		
Baltimo	43	21. Signatura of Funeral Service Lie					SINGLETON			
Depariment of the property in the property is any in the property in the prope		> Muchall	2 COONEL	₽ <sub>MO1415</sub> 1	SECOND A	AVE. SW	, GLEN BU	RNIE, MD	210	61
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus	ed the death. Do not en	nter the mode of dyi	ng, such as c	ardiac or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	1	NARY A	PRTERY	Dis	SASE			Onset and Death
/Medical Examiner		resulting in death)		as a consequence of):	. /					/ (413
Examine		Sequentially list conditions,	b. GENS	as a consequence of):	DATH	LENOS	CLERO	SIS		6/000
rted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	000 10 (0)	as a consequence or,						W 75
60, -> be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or a	as a consequence of):						
o ys	cai		d							
	Medi	IF FEMALE:								
Box 68 eath certific attending pl	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc	y			ite of deliver	y Day Year
O. De de he de the de fined for	Physician/Med	1 Yes 2 No	4□ Pregnant 9□ Unknown	at time of death 5	Other (specify) _			IVIC	Jintii (	Day 1 Bai
IS, P.O.	Ph	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Dio	I tobacco use cont	tribute to the	cause of death?
Records, he law requires t e has been signe tge 2 should be	d by	DINBETES	MELLI	+US To	10.2-2		1	Yes 2 □ No	3 Proba	ibly 4 Unknown
COLD w require been signatured by	Completed	ANEMIA		/	7		24a. Wa	s an 24b	Were auton	sy findings available
The lav	E O		-				aut per	opsy fornied?	prior to com death?	pletion of cause of
	a)	25. Was case referred to medical				26. Place o	1 ☐ Yes	The state of the s	1 ☐ Yes	No No
	To B	examiner?	Hospital: 1 ☐ Inpa	tient 2 ER/Outpatie	nt 3 DOA Oth	oc:	sing Home 5 XRe	Accessed to the second	ner (Specify)	
On Of ding Phy h. After this funeral d		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, E	jury 28b. Time ( Day Yeer) Injury	of 28c. Injur Wor	y at rk?	28d. Describe	how injury occur	red	
VISIO Ntendi death. ctor: A y the fu	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	the -			Yes 2 □No				
DIVISION Il or Attending after death. Director: Afte	Certification;	4 Homicide determina	ad 286. Place of I	njury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location City or To	(Street and Numb own, State)	per or Rural	Route Number,
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier Certifying	Physician: To the be:	st of my knowtedge, dea	th occurred at the tu	me date and	place, and due to the	a causa(s) and ma	anner as sta	ted
124 h	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner	of examination and/or if	nvestigation, in my o	pinion, death	occurred at the time	, date and place,	and due to	the cause(s)
within 2 To the	×	29b. Signature and titte of certifier	0	-/1	29c. Licens	e number		29d. Date signed	d (Month, D	ay, Year)
	1	1 /Liel	ad Z	11)	Do	251	9	Janua	142	2005
/		30. Name and address of person wh	mpteted cause of	death (Item 23a) (Type	Print) / 1 1	/	1 1			1 1
2		31. Date filed (Month, Day, Year)	Shor M	D (RA)	W HIVE	1/ YE	DAIN 1	DWERS	21	061
Si Regis	ate trar	JAN 0 6		mais signature		( '				
DHMH 17 Rev 1/		DAN V 6	JOB COUNTY	w #	and I					
				ORIGIN	IAL					

			For State Registrar	State of M	aryland	/ Depa	artmen tificate	t of H	ealth a Death	and Mer		giene Reg. No.	004	4	2147
	Physicia		1. Decedent's Name (First, Middle, Last								Date of Dea	ath Day	Ye	ar 3.	3. Time of Death
	/Medic		Mary Jane W. Mahor								cembe				9:21 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give Montgomery General				4b. City, 01ne		Location o	of Death			County of E ntgom		
	Eunaval		5. Social Security Number 6. Se		ige (In yrs. las	st birthday)	If Under	1 Year	If Under :		Date of Birt	b			a (State or Foreign
	Funeral Director			]M 2⊠F	83	Yrs.	Months	Days	Hours	Min.	(Month, Da ctober	20, Year)		Country	lvania
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							10d	Inside City Limits
	/anyla	5	Maryland Montgomer	• • • • • • • • • • • • • • • • • • • •	,	er Sp									1 ☐ Yes 2½ No
	28a-	rect	10e. Street and Number	У	DITA	er ph	10f. Zip	Code				10g. Citiz	en of Wha	t Country?	?
	h with	i Di	15301 Wallbrook Co	urt, Apt	. 3G		209	06				Unit	ed St	ates	
	72 hours after death with the Maryland natural', or items 23s or 28s-f show disal Exaciliser count be notified at	Completed by Funeral Directo	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S.	. 13. \	Was Deced	lent of His	spanic Orig	gin? (Specify , Puerto Rica	Yes or No	- 1	4. Race - /	American I White, etc.	
36	or it	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 12 If Yes, Give	] No		1 □ Yes		Specify:				Specify:		
9	tural to	ed b	15. Decedent's Edu	Year or Dates		16a. Deced	dent's Usua	al Occupa	ıtion			16b. Kin	nd of Busin	White ess/Indust	
215	nin 72 In "ne	piet	(Specify only highest grad	e completed) College (1-4o		(Give	kind of wor DO NOT us	rk done d se retired,	luring most )	t of working					
21	giene giene er the	Com	12	_	.,	Home	maker	•					Home		
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last) Arthur H. Wagener							r's Name <i>(Fi</i> tha G.			Sumame)		
ryla	hould d Men marke matic	ို	19a. Informant's Name/Relationship (T)	ine Print)		10h Mailir	a Addross	(Street a					Town Sta	te Zin Co	de) 22304
Maryland 21215-0036	d 2 si th an th an 27 is r traur		Stephen Mahoney/ S							reet,					,
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet man to notified at Ance.		20a. Method of Disposition		l cer	ce of Dispo	sition (Nan	ne of	9)	Date		20c. Loc	ation - City	y or Town,	State
Baltimore,	Page nent o nat: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)		° Ar Nati	lingto onal	on Cemet	erv	1	Januar 2005	-	Arli:	neton	, Vir	ginia
alti	Departn Departn Importe any inju		21. Signature of Funeral S vice Licens	09		22	. Name an	d Addres	s of Facilit	Rober	t A.	Pumpl	hrev	Funer	al Home/
_	89 = 9		My ()		689	KO	CKV11	Roc Roc	kvil	300 le, Ma	rylan	d 20	50mer 550-2		
			23a. Part1. Lyter the disease, or comp shock, or heart failure. List only o	lications that caus ne cause on each	ed the death. line.	Do not ent	er the mod	e of dying	g, such as	cardiac or re	spiratory ar	rest,		Inte	proximate erval Between aset and Death
	Pnysician   /Medical		Immediate Cause (Final disease or condition resulting in death)	a	lumo	ma	_								Week
į,	Examiner			Due to	a conseque	ence of):	_		e for	rosi	,				
	No.	Jer	Sequentially list conditions, if any reading to immediate	b. Due to (or a	s a conseque	ance of):	3	V							
	cuted nd ransit	Examine		c.										- 12	
90,	certificate be executed ding physician and use as the burial-transit	I Ex	resulting in death) Last	Due to (or a	is a conseque	ence of):									
8760,	icate b physic s the b	dical		d											
9 X	death certifica a attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnance	су						2	3d. Date of	delivery	
Вох	atter for u	iciar	in the past 12 months?		2 ☐ Fetal d at time of dea		Ectopic pr Other (sp						Month	Day	y Year
P.O.	t the	hys	9 Unknown	9□ Unknown											
	res that signed I be det	by F	Part II. Other significant conditions co	ntributing to death	but not result	ting in the u	nderlying c	ause give	n in Part I.				_		ause of death?
ord	law requires as been sign 2 should be	eted										∕es 2□		Probably	
Vital Records,	e law has b	Completed									24a. Was autop		24b. Wer prior deat	r to comple	findings available etion of cause of
alF	Th ate pag		OS Was soon referred to modisal		·				00.01	- ( D - + ) ( O	1 🗆 Yes	25/10	1 🗆		] No
		o Be	25. Was case referred to medical examiner?	Hospital:	tient 2 TF	R/Outpatien	nt 3 DC	Othe		of Death (C rsing Home			Other /	Specific)	
10		-	27 Manner of Death	28a. Date of In	jury 2	28b. Time of		8c. Injury Work			. Describe I			эроспу	
sior	Attending Indeath. Sector: After by the funer	atio	2 Accident 5 Pending investigation	(111/21111)	,		М		/es 2 □ l	No					
Division	or Attendation of Director:	ertification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I building,	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	eet, factory	, office		28f.	Location (S City or Tox		Number o	r Rural Ro	oute Number,
	Hospital 24 hours a Funaral D tely filled i	O	29a, Certifier Certifying Phy	rsician: To the be	et of my know	ledge death	3 accurred	at the tim	o date an	d place, and	due to the	C31150(6)	and manne	r ac ctator	d
	To the Hospital or Ai within 24 hours after or To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Exam		of examinationstated.	on and/or in	vestigation	in my op	oinion, dea	th occurred a	at the time,	date and	place, and	due to the	cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier		N /	0	290	. License	number			29d. Date	signed (N	fonth, Day	Year)
)	7		Wilkenson	2 ~	Viv	rala	- 3	DY	-50	782		Dec	eembe	231	, 2004
	30		30. Name and address of person who g	_	death (Item 2	23a) (Type,	Print)	jBh	rd #	113,	Silvi	neg	ning	, Md	(, Year) 1, 2004 1, 2090
	Sta		31. Date filed (Month, Day, Year)	61	strar's Signatu	ire	and a								
	Registr	ar	JAN 0 6 20	05 Bar	you do	154	The state of the s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. ZUUL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 6:00 PM **Physician** DECEMBER 300 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WINDEMERE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 X F Months Days Hours 242-26-9643 Yrs. SOUTH CARDUNA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28a-f ahow other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18 Items 23g 1538  $\Im$ 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DVERNMENT Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD L. NEALE SR. PAUTIMORE MD 21 20c. Location - City or Town, State itam 27 Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition Date of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6 Department of Important: If any injury or once. \* 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility.
Daugherty Family Funeral Home and Cremation Center, P.A.
2601 Mantain Rd. Pasadene, MD 21122 21. Signature of Eugeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Priysician 5 years Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death Day in the past 12 months? 1 ☐ Yes 2. No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. director, page 2 should be detached 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√7 No 24a. Was an 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 🗌 Yes 2₩ No 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3 DOA 4 ☐ Nursing Home 5 ₹ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 Accident Injury 5 Pending 1 🗌 Yes 2 🗌 No 24 hours after death. investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie f Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2. 29d. Date signed (Month, Day, Year) Signature and title of certifier D005485 Lanuary 03, 2005 alb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Colleen Christmas MD 5505 Hopkins Bayview Circle

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Maryland /	Department of H			2004	42149
	Physici	an	Decedent's Name (First, Middle, La		Commodic on		Reg. 2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, giv	U PEREZ	4b. City. Town or	Location of Death	ecember	<b>24 2004</b> 4c. County of Death	1437 M
	Examin	er	the MemoRIAL	HOSFITAL	EAS	TON	2	TALBO	
	Funeral Director		210.18,11.12	Fex 2 F 7. Age (In yrs. last to	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye	ear) 9. Birthp Count 124 KA	lace (State or Foreign otry)
	yland how		Usual Residence of Decedent  10a. State 10b. County	1	wn or Location		, ,	1	Od. Inside City Limits
	the Ma 28a-f s	Director	MD DORCI	HESTER CA	MBR IDG		100	Citizen of What Coun	1 XYes 2 □ No
	th with 23a or	al Dir	41 4 1 1	ASANT ST.		613	Ů	NITED !	STATES
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Modical Examinational be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 █ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 May 2 □ No	ispanic Origin? (Specin, Mexican, Puerto Ri	can, etc.)	14. Race - Americ Black, White, Specify:	an Indian, etc.
21215-0036	within 72 hor ene. than "natur	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		ia. Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	ation during most of working	166	. Kind of Business/Inc	
	filed with Hygiene. other than	Соп	17. Father's Name (First, Middle, Last		FACTORY	WORK	- 1	OULTR	.Υ
Maryland	should be ind Mental marked o	To Be	, , ,	TO RODRIG	UEZ		DIOS	43	NK)
Mar	nd 2 sho alth and 1 27 is mu		19a. Informant's Name/Relationship (	Type, Print) 19 LEN/DAUGHTER	9b. Mailing Address (Street a		0	501	21613
	Pages 1 and 2 nent of Health int; if Item 27 iry or other tri		20a. Method of Disposition  1  Burial 2  Cremation 3	20b. Place	of Disposition (Name of tery, crematory or other place	Da	104	. Location - City or To	wn, State
Baltimore,	permit. Page Department of Important; If any injury or once.		' 4 ☑ Donation 5 ☐ Other (Special 21. Signature ☐ F rail Service Licer	ANAT	TOMY GIFTS 22. Name and Addres	REG. 1420	904 H	ANOVER	MD
ä	Depa Impo any ir		A XXX	mis		2601 Mou	ntain Road - P	And Cremation Ce asadena, MD. 211	22
	Pnysician		Immediate Cause (Final	plications that caused the leath. Do	4	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to for as a consequence		a to solve	*		
	100	Jer	Sequentially list conditions, cause. Enter Underlying	b. Pue to (or as a oursequence		er also	ase		-
	xecuted and al-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	e of):				
68760,	ficate be executed physician and s the burial-transit	edlcal E		d					
Box 6	eath certific attending p for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delive	ry
P.O. B	that the death cert ed by the attendin detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 ☐Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
	sign d be	by	Part II. Other significant conditions of	contributing to death but not resulting	in the underlying cause give	en in Part I.		co use contribute to the	e cause of death?
Division of Vital Records,		Completed					24a. Was an autopsy performed 1 \( \text{Yes} \) 2 \( \text{2} \)	prior to con death?	osy findings available inpletion of cause of
Vita	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 ☐ ER/0	Other	26. Place of Death (		e 6 □Other (Specify	·)
o uc	Attending Physician: or death. ector; After this certifics by the funeral director. p		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of 28c. Injury Work	/ at 28	d. Describe how in		/
Divisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	e age Place of Injury - At home		Yes 2 □ No 28	f. Location (Street City or Town, Si	t and Number or Rura tate)	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edical	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Example	งงรัตเลก: To the best of my knowled กiner: On the basis of examination a and manner stated.	ge, death occurred at the time and/or investigation, in my op-	ne, date and place, an pinion, death occurred	d due to the cause at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
i	Jo Within Some	Σ	29b. Signature and title of certifier	completed cause of death (Item 23a)  2. Registrar's Signature	29c. License	number 00 566 5 9	? 29d.	Date signed (Month, L	Jay, Year)
6	1180		30. Name and address of person who Muttamman 4	completed cause of death (Item 23a	(Type, Print)	CAMBRIL	nue .	MD-2.	1613
	Sta Registr		JAN 0 6 200	2. Registrar's Signature	Goods!				

PEREZ, MARY

		1	For State of State of Registrar		artment of Health and Nortificate of Death	Mental Hygier	
	3 5	127	Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physicia /Medic	al	Arthur Pratt			December	27 20047:30A M
	Examin	<b>-</b> 1	ta. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Death Annapolis		Anne Arundel
			200 A Boxwood Rd. Apt  5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		219–16–1667	83 Yrs.	Months Days Hours Min.	Sept. 10	
1200	Alte V	- 10	Usual Residence of Decedent	10c. City, Town or Lo	antion .		10d. Inside City Limits
9	show	-	10a. State 10b. County				1½ Yes 2 □ No
1	28a-f	Directo	Maryland Anne Arundel  10e. Street and Number	<u>  Annapoli</u>	10f. Zip Code	10g.	Citizen of What Country?
-	oeaun with the Maryland ms 23a or 28a-f show r must be notified at			104	21403		IISA
4	Items 23	Funeral	200 A Boxwood Rd. Apt 11. Marital Status 12. Was Dece	tent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
_			1 Nover Married 2 Married 1 TYPS	2 🗆 No	1 ☐ Yes 2 ☑ No Specify:	,	Specify: Black
2-003p	tural", or ite	d by		tes] 944-46	dent's Usual Occupation	16h	Kind of Business/Industry
o i	2 8 4	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done during most of wor DO NOT use retired)	rking	. Tally of Eddinost Hudoliy
717	within iene. then	dwo	Etementary/Secondary (0-12) College (1-		andscapper	F	t. George Meade
פ	other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maid	den Surname)
Maryland	Menta Menta arked	To	Horace Pratt			ole Stark	
an i	2 should and Miles mark		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru		
	s 1 and f Health item 27 other t		Sheila Pratt (Daught 20a, Method of Disposition	20b. Place of Dispo	14 Angora Drive		:. Location - City or Town, State
altimore,	00		1 Burial 2 □ Cremation 3 □ Removal from 5 1 □ Donation 5 □ Other (Specify)	State Maryland	d Veteran	3 2005	Crownsville, Md.
	permit. Page Department Important: If eny injury or once.		21. Signature of Funeral Service Licensee	Cemeter	Name and Address of Facility		
B	Ped		Larry & Reese MOO	183 Wm	. Reese & Sons 21 West St. Anr	Mortuary	Md. 21401
	X-1-1-1		23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause only	sused the death. Do not en	iter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	yncardial	interction hi	ikely	mivutes
	/Medical Examiner		resulting in death)	as a consequence of):		1	1110.0
	_xummer	10	if any, leading to immediate b. Due to (	or as a constituence of):	20512	V	years.
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	intoker c	Mellitus to	v 2	Leus.
ó	te be executed ysician and te burial-transit			or as a consequence of):	1 //		/
	2 2	Ical	d				
x 68	The law requires that the death certifica ate has been signed by the attending ph age 2 should be detached for use as t	Physician/Med	IF FEMALE: 23c If yes out	come of pregnancy	-17-	Missa s	23d. Date of delivery
Вох	attenc for us	ian	in the past 12 months?	irth 2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)		Month Day Year
o.	the de y the iched	ysk	1 Yes 2 No 9 Unknown	own .			
S, D	s that ned b e deta	by PI	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause given in Part t.		co use contribute to the cause of death?
rds	w requires to been signer should be		HyperTension.			1 Ves	2 No 3 Probably 4 Unknown
Vital Record	law reas be	Completed	•/			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Ξ Ξ		Con				1 ☐ Yes	No 1 ☐ Yes 27 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	eath Check onl one	a 6 Other (Specific)
of	Phys this ral dii	5	27 Manger of D ath 28a. Date	npatient 2 ER/Outpatient 28b. Time	of 28c. Injury at	28d. Describe how	ee 6 ☐Other (Specify) intury occurred
OU	Attending Ph r death. ector: After th by the funeral	tlon	1 Naturat 5 Pending (Mon 2 Accident investigation	th, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division	or Atten after deat Director: in by the	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, s	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Ö	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the					1	
	e Hospital 24 hours a e Funeral C	ledical	(Check only 2 Madical Examiner: On the b	i best of my knowledge, dea asis of examination and/or i ner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the comple	Med	one) and man 29b. Signature and title of certifier	N N	29c. License number	29d	. Date signed (Month, Dey, Year)
	with To com		Va. O. P. Centre	w W)	D-0018566	,	2/30/2004
1	11		30. Name and address of person who completed cause	se of death (Item 23a) (Type	e, Print)	N 1	Lake IIN sidal
10	7 )		CHANES P. ADAMO	MD 180-1	Admiral Jochnan	eth. ANN	MID SILVE VIDE
	St	ate	31. Date filed (Month, Day, Year) 32. F	tegistrar's Signature	BI		r

DHMH 17 Rev 1/2001

			For State Registrar	State of	f Marylan		artment of H tificate of L		d Mental Hy	gien <b>e</b> [] Reg. No.	04	42151
	Physici	20	1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	eath Day	Yeer	3. Time of Death
	/Medic		Charles Ross						Decemb			
	Examin		4a. Facility Name (If not institution, Anne Arundel N	-			4b. City, Town, or Annapo		eath		nty of Death C Aru	
	Funeral Director		5. Social Security Number 215-16-7490	6. Sex 1 X M 2 □ F	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Bin (Month, Date of Bin 12		Cou	place (State or Foreign ntry) rland
	pu 🛾		Usual Residence of Decedent  10a. State 10b. County		10c Cib	/. Town or Lo	cation					10d. Inside City Limits
	Aaryla f shor	ö	Maryland Anne	Arundel		napol						1X Yes 2 No
	28e-	Funeral Director	10e. Street and Number			-	10f. Zip Code			10g. Citizen o	of What Cou	ntry?
	h with	al DI	1008 Monroe S	t.			21403			USA		
	ams a	ner	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of Hi	spanic Origin?	? (Specify Yes or No uerto Rican, etc.)	o- 14. R	lace - Americ	
21215-0036	be tiled within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or Itams 23a or 28e-f show avent, the Medical Examinar must be motified at avent, the Medical Examinar must be motified at		1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 XYes			1 □ Yes 2√∑ No	Specify:			cify: B1	
20	72 ho natur	Completed by	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occupa	ation furing most of	working	16b. Kind of		
7	within ene. than "	mple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired	)	g	Unite Naval		
	tited within Hygiene. other than ant, the M		12th 17. Father's Name (First, Middle, L	ast)		Cus	todian	18. Mother's	Name (First, Middle			acmy
Maryland	should be to nd Mental I markad ol imetic ava	To Be	Eugene Ross				1		Johnson	,		
ary			19a. Informant's Name/Relationsh						r Rural Route Numb			Code)
	1 and 2 Health a am 27 is	1	Dorothy L. Ros	s(Wife)				St. A	Annapoli			
ore			20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from	State   C	emetery, crer	sition (Name of natory or other place		Date	20c. Locatio		
Baltimore,	t. Partmen		' 4 □ Donation 5 □ Other (Sp.		Mar		Vetera					e, Md.
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	0	00483	M	m. Rees 21 West	e & Sc St. I	ons Mort Annapoli	uary, s, Md.	P.A. 214	01
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that called one cause on e	aused the death ach line.	n. Do not ent	er the mode of dying	g, such as car	diac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Se	ptic	54	ock					
	/Medical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Due to	or as a consequ	uence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (	(or as a consequ	uence of):						
	cuted Id ansit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events	c								
Ö,	e exec ian ar urial-tı		resulting in death) Last	Due to (	(or as a consequ	uence of):						
68760,	icate be executed physician and s the burial-transit	edical		d							-	
	n certific anding p use as		IF FEMALE:	23c If yes out	come of pregna	nev	73.7.3			024	Data of dalis	
Вох	eath certif attending for use a	clan	23b. Was decedent pregnant in the past 12 months?	1 Live b	eirth 2 Tetal	death 3[	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
0	at the de by the a tached	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno								
Vital Records, P	ss tha	by	Part II. Other significant condition  A trial 6.4	or lation		ulting in the u	nderlying cause give	en in Part I.		tobacco use co Yes 2 □ No	0.00	he cause of death?
00	w require s been sig	Completed							24a. Was		b. Were auto	opsy findings available
Re	The lav	шо						• •	auto	psy ormed?	death?	ompletion of cause of
ita		Be C	25. Was case referred to medical examiner?		333			26. Place of	Death (Check only			
of V	Physicien: this certificatal director, I	70	1 Yes 2 No			ER/Outpatier		4	ng Home 5□ Res			fy)
	ding P h. After t funera	iuol	27. Manner of Death  1. Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury	Work	rat <br Yes 2 □ No	28d. Describe	how injury occ	urred	
Division	death death ctor: / the	licat	2 Accident investigation investigation   Accident   Acc	ot be	of Injury - At ho	me. farm. str	eet, factory, office	195 2 100	28f. Location	Street and Nu	mber or Rur	al Route Number,
Οİ	Die te	Certification:	4 Homicide determin		ng, etc. (Specify		cot, raciory, ornoc			wn, State)		
	To the Hospital within 24 hours a To the Funerel Completely filled	edical (		Physicien: To the xeminer: On the ba and mann								
	To th withir To th compl	Me	29b. Signature and title of certifier	. ~			29c. License	number		29d. Date sign	ned (Month,	Day, Year)
	1		Vin	WE	2	m	000	5763	5	Dec	31	2004
1	XI		30. Name and address of person w	_		23a) (Type			4	6	-	2004
	C	to	31. Date filed (Month, Day, Yeas)	2001	legistrar's Signa	KICA-	Moder	m	Annyol	y m	2 2	21401
	Sta Registr		JAN'U T	2005	ever li	A POS	WED	•				

- a		AK State Amend Item Registrar  1. Decedent's Name (First, Middle, Li		-						2. Date of De			3. Time of Death
Physicia		William	H. Smo	ak						DEC.	25, 20	Year 004	1005 A-M
/Medic Examin		4a. Facility Name (If not institution of				4b. City. T	Town, or EST	Location of HEIG	of Death HTS		4c. Coun	ty of Death	
Funeral		5. Social Security Number 251-32-5564	Sex 7. 12 M 2 ☐ F	Age (In yrs.		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D	ay, Year)		place (State or Foreign
Director		Usual Residence of Decedent		75	Yrs.					June 2	9,1929	South	Carolina
72 hours after death with the Maryland 'naturel', or items 23a or 28e-f show Jical Evarriner must be inditted at	ō	10a. State 10b. County  MD Prince 0	Correct		y,TownorLo rrest		<b>+</b> c						10d. Inside City Limits  MXYes 2 □ No
r 28e-f	irect	10e. Street and Number	eorges	FU	rrest	10f. Zip					10g. Citizen of	What Cou	
23a o ust ke	ai D	133 North Huron	Ave.				2074	<b>+</b> 5			US	A	
Department of Health and Mental Hygene.  Department of Health and Mental Hygene.  By injury or other treumetic event, the Medical Examinat must be indiffed at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Deced Armed Force LYWes 2 If Yes, Give Year or Dat	es? . 🗌 No		Was Deced If Yes, spec 1 ☐ Yes 2		ispanic Ori in, Mexicar Specify:		cify Yes or N Rican, etc.)	o- 14. Ra Bl Spec	ice - Americack, White, ify: Wh	
e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4	lor 5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	ation during mos f)	t of workin	g	16b. Kind of	Business/In	dustry
her th it, the		12			M	ainte	nanc		ode Nome	/Circh haidele	Pvt		
rked of	To Be	17. Father's Name (First, Middle, Las  Hubert Smo	_								e, Maiden Suma Cerpilla		
reume		19a. Informant's Name/Relationship				_	(Street a	and Numb	er or Rural	Route Numb	er, City or Town	n, State, Zip	
item 27 other t		Nelson Pumphrey/I 20a. Method of Disposition		20b. P							ills, M		0748 own, State
ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Spec		ate Geo Med	. Wásh ical C	. Uni enter	vers	ity De	ec.25	,2004	20c. Location Washin	gton,	DC
Departi Importi any inj once.		21. Smature of Juneral Service Lice	ens De.		22	2. Name and	d Addres	ss of Facilit	tv		soc Inc 2		
		23a. Part1. Enter the disease, or cor shock, or heart failure. List on! Immediate Cause (Final	y one cause on eac	used the deatl ch line.	h. Do not ent	ter the mode	e of dyin	g, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between Onset and Death
ysician ledical		disease or condition resulting in death)	a. Huc Due to (o	VOSCI rasaconseq	evoto, uence of):	c (0	lvdi	cvas	cala	v 120	seas e		
miner	1	Sequentially list conditions,	b. Due to (o	r as a conseq	nence of):	-							
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.	43 4 0011364	donce oi).								
ohysician and the burial-transit		resulting in death) Last	Due to (o	r as a conseq	uence of):								
ng phys	Wedic	IF FEMALE:	d										
ned by the attending ph detached for use as th	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		th 2 ☐ Feta nt at time of d	ildeath 3□	□Ectopic pre □ Other (spe						ate of delive lonth	ery Day Year
s been signed b should be deta	by	Part II. Other significant conditions Chowic Obstru		_						1	tobacco use co Yes 2 ☐ No		he cause of death?
s been shoul	oletec		10000	arvy	7,700,0		ast			24a. Was	san 24b	Were auto	posy findings available
s certificate has t lirector, page 2 s	Completed									auto perf 1 Yes	ormed? 2 No	death?	mpletion of cause of 2 No
certific irector,	Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:	patient 2	ED/Outration	nt 3□ DO	Othe			(Check only	one) idence 6 💥o	/ /	AT SCENE
After this funeral dii	on: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month)		28b. Time of		8c. Injury Work	4 🗆 140			how injury occu		M AT DOEME
death. c <b>tor</b> : A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not	be and Black	f Injury - At ho	ome farm str	M factory		Yes 2 🗌		8f. Location	Street and Nur	her or Run	al Route Number,
0 0	ŧ	4 ☐ Homicide determine	building	g, etc. (Specif	y)	eet, ractory	, onice			City or To	wn, State)		a) 1 (5016 1105),
ed in t	Cer	29a. Certifier 1 Certifying F	hysicien: To the base	is of examina	wledge, death tion and/or in	h occurred a vestigation,	at the tim	ne, date ar pinion, dea	d place, a	nd due to the d at the time	cause(s) and n date and place	nanner as s , and due to	stated. o the cause(s)
n 24 hours afte ne Funerel Din pletely filled in t			and manne	or statou.									
within 24 hours after death.  To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	Medical Cer	(Check only 2 Medical Exe	and manne	, 100	1	29c.	. License	e number C.M.E			29d. Date sign		Day, Year) 2004
within 24 hours after death. To the Funerel Director: After	edical	(Check only 2X Medical Execute)	and manne	ind	7 723a) ( <u>Type</u> .		0.0	C.M.E	TTM∕T	TE MADS:	DEC.	25,	
~	Medical	(Check only one)  25 Medical Execution 29b. Signature and title of certifier	and manne	ind	II PEN		0.0	C.M.E	TIMOR	E,MARY	_	25,	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #26 PER VERB G839 1/06/05 CHrificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Sec. 2:19 AM hanes 4b. City\_Town, or Location of Death 4a Fecility Neme (If not institution, give 4c. County of Death sinai If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (Stete or Foreign Months Deys 216-86-8351 150 M 2□ F Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits 1 des 2 No Marxland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 D If Yes, Give Year or Dates: 2 1 No 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

DISASE 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) laulo. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Neme of cemetary, cremetory or other) 20e. Method of Disposition Date 1 Burial 2 Deremation 3 Removel from State Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Feodity 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 1 No 3 Probably 4 Unknown reaidos is 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an eutopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpetient 3 ☐ DOA Other: 4 Hyursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner ettending physicien end I for use es the buriel-trensit Hospital or Attending Physician: The law requiras that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours aftar death.

To the Funers! Director: After this certificate has been signed by the e completely filled in by tha funerel director, page 2 should be datached !

**Physician** 

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

permit. Pages I and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28af show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

by Physician/Medical Examiner Completed Certification: To Be 4 Homicide edical ( 29e. Certifier

25. Wes cese referred to medical exeminer? 1 Yes 2 → No 27. Menner of Death 1 Natural 2 Accident 3 Suicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. 29b. Signatura end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 1B GOOD 9

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

JAN 0 6 2005

**DHMH 16 Rev 6/95** 

1

State

Registrar

**ORIGINAL** 

			1 - State of Marylar	d / Department of Health and Mental Hygiene  Certificate of Death	
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)	2. Date of Death Day Year  Ab. City, Town, or Location of Death  4c. County of Death	Prime of Danh
	Funeral Director		5. Social Security Number  6. Sex  179-22-4248  1 M 2 F 75  Usual Residence of Decedent		e (State or Foreign
	th the Maryland or 28e-f show e notified at	Irector	10a. State 10b. County 10c. Ci		Inside City Limits 13☑Yes 2☐No ?
9003	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other then "neturel", or Items 23a or 28e-1 show other treumetic event, Ite Madical Examinational be notified at	d by Funeral Director	9101 Second Avenue  11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in UArmed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  □ Yes 2 No Specify:  Specify: White	te
121215-0036	filed within 72 h Hygiene. ther then "neti	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working (iffe. DO NOT use retired)  Research Assistant  Library of Co	
Maryland	2 should be filed within and Mental Hygiene. is marked other then eumetic event, I'le Me	To Be	17. Father's Name (First, Middle, Last) Charles Frederick Sloan  19a. Informant's Name/Relationship (Type, Print)	18. Mother's Name (First, Middle, Maiden Surname) Sidney Showacher  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.	de)
Baltimore, N	9 = 5		1 C Busiel 2 M Committee 2 C Doministration State	224 Anderson Ln; Ambler PA 19002  lace of Disposition (Name of Date 20c. Location - City or Town, ametery, crematory or other place)  rt Lincoln Crematory 1/2/2005 Brentwood, MD	
Balti	perrit. Pa Depertmen Importent: any injury		21. Signature of Funeral Service Licensee  Myelint, Wholest	22. Name and Address of Facility Fort Lincoln Funeral Hom 3401 Bladensburg Road Brentwood MD 207	
	Physician /Medical		Immediate Cause (Final	iorespiratory Arrest T	pproximate terval Between nset and Death mmed
8760,	certificate be executed rding physician and use as the burial-transit	dical Examiner		rtery Disease	U Yrs
.O. Box 6	the death y the atter ached for u	Completed by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of outcome of pre	death 3 Ectopic pregnancy	y Year
rds, P.	tw requires that the s been signed by th should be detache	ed by Pl	Part II. Other significant conditions contributing to death but not re- Carcinoma Prostate	ulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause in Part I.  1   Yes 2   No 3   Probably	
Il Records,	The law ate has b page 2 s	Complete	Carcinoma Bladder Chronic Urosepsis	24a. Was an autopsy prior to comple death?  1 □ Yes 2√√ No 1 □ Yes 2 □	etion of cause of
n of Vital	ding Physicien: The h. After this certificate h. funeral director, page	To Be	27. Manner of Death 1 ⊠Natural 5 ☐ Pending (Month, Day Year)	26. Place of Death (Check only one)  ER/Outpatient 3 DOA Cher: 4X Nursing Home 5 Residence 6 Other (Specify)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred	
Division	or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At houiding, etc. (Special Country)	M 1 ☐ Yes 2 ☐ No  when, farm, street, factory, office  28f. Location (Street and Number or Rural Ro City or Town, State)	oute Number,
	To the Hospitel within 24 hours of To the Funerel completely filled	Medical C	29a. Certifier  (Chack only one)  1 Certifying Physician: To the best of my kn (Chack only one)	wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated tion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	d. e cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier  2 de Oaugh Roller	29c. License number 29d. Date signed (Month, Day 12/27/20	
	3		30. Name and address of person who completed cause of death (Ite Edward DeVaughn Belton MD	23a) (Type, Print) 1629 Columbia Road NW Washington DC 20009	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 0 6 2005	k facts	

DHMH 17 Rev 1/2001

	Baltimore, Maryland
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	livision of Vital Records, P.O. Box 68760,
	ion of Vit

			Please				k. Ensure All	•	-	
			1 - For State Registrar	State of Ma		ertificate of	Health and Me Death	ental Hygle Reg.	2001.	42155
-	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of Death  Month	<sup>Day</sup> 28, 200	3. Time of Death
	/Media		Samuel F. Sp							
	Examir	er	4a. Facility Name (If not institution, giv				or Location of Death		4c. County of Deat	h
Н			VA MARYLAND HE 5. Social Security Number 6. S		e (In yrs. last birthda		PERRY POI	N'T' 8. Date of Birth	CECIL	hplace (State or Foreign
	Funeral Director			NEM 20F	7.4 Yrs.	Months Days	Hours Min.	(Month, Day, Ye		hplace (State or Foreign untry)
			Usual Residence of Decedent					ПУ 28.	1930 Mar	yrand
í	arylan show	_	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
)	8a-f e	cto	Maryland		Baltimo					1 Tyes 2 XNo
1	death with the Maryland ms 23a or 28a-f ehow Imust be notitied at	I Dire	10e. Street and Number 3801 Dorchester	Rd.		10f. Zip Code 2121	5	10g.	Citizen of What Co USA	untry?
	Jeath ms 20	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of	Hispanic Origin? (Spec	ify Yes or No-	14. Race - Ame	rican Indian,
920	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	by Funeral Director	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?    XX Yes 2       Yes, Give Year or Dates	958-64	If Yes, specify Cut  1 ☐ Yes 2 X No	pan', Mexican <sup>*</sup> , Puèrto R Specity:	ican, etc.)	Specify: B	a, etc. 1ack
2-0	72 ho	eted	15. Decedent's E	ducation	16a. Dec	edent's Usual Occu	pation	16b	Kind of Business/	Industry
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 Is marked othar than "r traumatic evant, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	Reso	urce Ad:	during most of working ad) Human ministrat	or So	ltimore cial Se	
p	al Hy al Hy d other	Be (	17. Father's Name (First, Middle, Last, Moses Spicer	) 1			18. Mother's Name		den Sumame)	
<u>Va</u>	Ment Ment Birke aric e	2	Moses Spicer				Mary Tay	lor		
	and 2 sho alth and 127 Is m		19a. Informant's Name/Relationship ( Laura M. Spicer		3		tand Number or Rural ster Rd.		ty or Town, State, 2 lore, Md	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If itam 27 Is any injury or othar tra <u>once.</u>	0	20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif			oosition (Name of ematory or other pla remator	· 1		Location - City or . 1timore	
Ħ	permit. Page Department ( Importent: If any injury or		21. Signature of Funeral Service Lice				ess of Facility e & Sons	<b>-</b> -		,
ä	Depa Impo any i		Larry B. Ree	ORMOSY8:	3 8	m. Kees	e & Sons St. Anna	mortuar	у, Р.А. Ма. 214	01
			23a. Part1. Enter he disease, or com shock, or heart failure. List only	plications that caused	the death. Do not e				ilie wastesallaski	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aN	EW CEREB	ROVASCU	LAR ACCID	ENT		Onset and Death
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	cuted Id ransit	Examiner	Cause (Disease or injury that initiated events	C.						
60,	be execut ician and burial-trar		resulting in death) Last	Due to (or as	a consequence of):					
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, e	certificate Iding physise as the	Med	IF FEMALE:		,					77,
P.O. Box	death e atter ed for u	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	у		23d. Date of deli Month	very Day Year
	Se GB	by Pr	Part II. Other significant conditions of HYPERTENSION	contributing to death b	ut not resulting in the	underlying cause g	ven in Part I.		co use contribute to	the cause of death?
0.0	w requires been sign should be	eted								
I Rec	The lar ate has page 2	Comple	SEIZURE DISOR	RDER				24a. Was an autopsy performed	24b. Were au prior to death?	topsy findings available completion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death			
of	ys dis	2	1 ☐ Yes 2 ☒No  27. Manner of Death	1 ∐ Inpatie		ent 3[] DOA			6 □Other (Spec	eity)
UC	ng fter	lon	1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) Zob. 11119 Injury	Wo	rk? ]Yes 2 □No	ld. Describe how in	nury occurred	
Division of Vital Records,	or Attending after death. Diractor: After in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, s c. (Specify)			If. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
_	To the Hospital or Attendii within 24 hours after death. To the Funeral Diractor; A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Exer	nysician: To the best miner: On the basis of and manner sta	f examination and/or i	ath occurred at the t	ime, date and place, ar opinion, death occurred	d due to the cause at the time, date a	a(s) and manner as and place, and due	stated. to the cause(s)
	o tha	Me	29b. Signature and title of certifier			29c. Licen	se number	29d.	Date signed (Month	Day, Year)
	- > - 0		* Alelina	Sants	M. A	151	094-1	DEC	EMBER 2	8, 2004
١	X		30. Name and address of person who	completed cause of d	leath (Item 23a) (Type	e, Print)				
	,		MELECIA SANTOS			ND HEALT	HCARE SYS	STEM, PI	ERRY POI	NT, MD
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 0 6 200	2. Registr	ar's Signature	Re)				
			77111 0 0 EUU	The state of the s	200 M					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death AULIN Month Year **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ity of De Examiner If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 214-26-7 Days Hours Country 1 □ M 2X F 180 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show other traumatic avant, the Madical Examiner must be notified at 18 Yes 2 No Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? 12 or Itams 23g filed within 72 hours after death Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 □ Divorced BLACK "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than LOTIFING MANUFACTURES 7 +HGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FROSS 2 WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. RTLE WALKER (DAUGHTER MD 21229 57. 20a. Method of Disposition

1 Degrad 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 01-05-05 LAUREL, MARYLAND 5 Other (Specify) any injury 22. Name and Address of Facility 21. Signature of Funeral Service Ligens JR. FUNERAL HOME FULTON Do not enter the mode of dying, such a carriac or respiratory arres 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseq. **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day Year in the past 10 months? 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant condition contributing to death but part resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 certificate has 1 Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one examiner? Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Manne of Deat After Injury Natural 5 Pending 1 TYes 2 No investigation 2 Accident filled in by the within 24 hours after deat To the Funaral Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of coctifier

State Registrar

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30. Name and address of parson

31. Date filed (Month, Day, Year)

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32. Registraç

			1 - For State Registrar AMEND ITEM	State of Man	•			Mental Hy	(1	104	42157
			Decedent's Name (First, Middle, Last		00-10 2/4	107 63.001		2. Date of D	Reg. No.		3. Time of Death
	Physici	an	DOGAN	•/		TA	SOZ	Month	Day	Year	06: Z4 M
	/Medic			atract and aumberl		4b. City, Town, or		Decembe		y of Death	00.244
	Examir	ier	4a. Facility Name (If not institution, give	of and namber	0:101	40. Gly, 10WII, 01	( ) ) ) s	7	40. Count	y or Death	
			5. Social Security Number 6. So	KINS TIUS	n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	rth	0 Riebo	lace (State or Foreign
	Funeral Director			TM 2015	56 Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Coun	ntry)
		'	Usual Residence of Decedent		<i>,</i>			TIAK I	1940	TUR	KEY
	land ow		10a. State 10b. County	- 10	Oc. City, Town or Lo	ocation				1	0d. Inside City Limits
	Man,	ţō	NJ MONMOUT	ч	MANALAPA	N					1 ☐ Yes 2 ☐ No
	28a	rec	10e. Street and Number		TIMINALIAI A	10f. Zip Code			10g. Citizen of	What Coun	atry?
	3a or	0	343 PINE BROOK RI	)		07726			U	84	
	within 72 hours after death with the Maryland ene. than "natural", or liems 23a or 28a-f show ta Madical Everifier maal be notified at	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S	pecify Yes or N		ce - Americ	
(0	r Ite	F	1 Never Married Married	Armed Forces? 1 ☐ Yes 2 XNo				o Rican, etc.)	Bla	ck, White,	etc.
93	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Speci	ty: WI	hite
21215-0036	2 ho	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ition		16b. Kind of E	Business/Ind	dustry
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21	d with	ШО	12.	0011090 (1.101.01.)		HAIR STYL	IST		SELF	EMPL(	DYED
	othe /ent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle			
Maryland	uld bu Menta Irked	To E	SEVET TASOZ				ELMAS	IBIS			
an	2 sho and Is ma		19a. Informant's Name/Relationship (7			ng Address (Street a				, State, Zip	Code)
	and ealth m 27 ier tr			BROTHER		CAMORE CT	, MARLBO				
ore	of H of H if iten		20a. Method of Disposition 1 Translate 2 Cremation 3		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place ${f T}$ . ${f MEM}$ . ${f P}$	112.2	Date	20c. Location	-	
Ē	Pages nent of h ant: If ite ury or of		`4 ☐ Donation 5 ☐ Other (Specify	)	JEKSEI 9	1. MEM. P	K.  12.2	0.04	MILLSTO	JNE, I	4.J.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If a Maches Execution and Le notified at once.		21. Sign up of Funeral Service Cen	1		ARYLAND M			NIE. MD.	. 2106	51
	А.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only								Approximate
	Observation		Immediate Cause (Final	one cause on each line.		C					Interval Between Onset and Death
	Pry <del>sici</del> an /Medical		disease or condition resulting in death)	a Due to (or as a c	remic	sups:	\$			>	2 weeks
	Examiner				are some com-	- ASSES	function				7
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of	~ dy (	FUN CHO	`			Luesca
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-	xecu and al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					_	
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687		edical		d.						1	200000000000000000000000000000000000000
	certil Iding	/Me	IF FEMALE:	23c. If yes, outcome of p	oregnancy				23d D:	ate of delive	nv.
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 { 4 ☐ Pregnant at time		Ectopic pregnancy Other (specify)					Day Year
Ö	the dr	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	0.000						
P.0	The law requires that the death certific ate has been signed by the attending r page 2 should be detached for use as	h.	Part II. Other significant conditions of	ontributing to death but r	ot resulting in the u	inderlying cause give	n in Part I.	23e. Did	tobacco use con	tribute to th	e cause of death?
Records,	sign d be	d by						1 🗆	Yes 2 No	3 Prob	ably 4 □Unknown
Ö	requ	Completed				-					
Sec.	e 2 s	ldu						24a. Was	psy	prior to con death?	psy findings available inpletion of cause of
<u>=</u>	: Th	S						1 Yes	2 No	1 ☐ Yes	2 No
Vital	Physician: The lav this certificate has al director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		0.4	26. Place of Dea				
of	hysi this c	은	I Tes 2 No	npatient	2 ER/Outpatier	nt 3 DOA	4 Nursing H				)
2	ng fter inei	on:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	Work	?	28d. Describe	how injury occu	rred	
Si.	Attending r death. sctor: After oy the funer	catl	2 Accident investigation 3 Suicide 6 Could not be				/es 2 □ No				
Division	I or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, sti Specify)</li> </ul>	reet, factory, office			(Street and Num wn, State)	ber or Rura	Route Number,
	urs al	ပိ		1							
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exem	/sician: To the best of n iner: On the basis of ex and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the rred at the time	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
	ithin (	Med	29b. Signature and title of certifier	and marrier states	4-	29c. License	number		29d. Date signe	ed (Month, I	Day, Year)
	F ≥ F 8		Access Hol	einan	MD.	70	1119				17,2004
			() 3								
			30. Name and address of person who	completed cause of deat: اد ص	n (item 23a) (Type,	G	oad Ho	sel man	U , W.	· .	
			31. Date filed (Month, Day, Year)	B Ranistrar's	Signature 4	whiper	ore, in	' '~)	41287	- 41	06
	Sta Registi		JAN 0 6 200	lave	No Ages	Baltim					

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eleanor Louise Tuck December 31, 2004 9:07 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Chevy Chase 4450 S. Park Avenue, #1413 Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 250 F 179-16-0709 Yrs. 1921 83 18, Director Feb. Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Manylend nent of Health and Mental Hygiene. and the filem 27 is marked other than "netural", or items 23s or 28e-f show ant: if Item 27 is marked other than "netural", or items 23s or 28e-f show unt; if manyle the instituted at ury or other traumatic event, it is Medical Eventher man be nettined at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Montgomery Chevy Chase 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4450 S. Park Avenue, #1413 20815 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ₺ No Specify: Specify: ģ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Dean Tuck Hazel L. Corbin 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. McCullough/Executrix 15337 Manor Village Lane, Rockville, MD 20853 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition considery crematory or other place)
Montgomery
Crematorium, Inc. Jan. 3, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2005 Rockville, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, ж0068Э Bethesda, Maryland 20814-3501 er the direase, or complications that caused that the Do not enter the mode of dying, such as cardiac or respiratory arrest, leaf failure. List only one cause on each line. Enfer the di Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Lung Adenocarcinoma 2 Months Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physician and for use es the buriel-transit Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 3 3 nknown ģ After this certificete hes been signs funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 - You 3 - 3 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 Yes 2 No 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide ò 24 hours 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1M.D. D0060129 January 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brent K. Cole, M.D. 5530 Wisconsin Avenue, #730, Chevy Chase, Maryland  $^{20815}$ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 1 4 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** December 2004 12:05PM Mattie Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Millennium @ South River Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 1903 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ VF 101 Yrs. 577-26-0219 Director Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28e-f show any injury or other treumatic event, Ite Medical Examination will be multiled at ODEs. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □XYes 2 □ No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 701 Glenwood St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martha Terrell Fleming Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1956 Forest Dr. Annapolis, Md. 21401 Velma McCullough(Niece) 20b. Place of Disposition (Name of Haren Menne of Place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1 - 5 - 05Landover, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. Larry B. Bess MOOY 83 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac Physician disease or condition resulting in death) mikuk /Medical **Examiner** theroscleronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ed by the attending physician and detached for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ☐ Wiknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dement 24a. Was an this certificate has 1 Yes 2 ₽No : After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 👺 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 50653 eyan. C 12-31-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. Churchton Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistrarAMEND TTEM #1 PER PHY C839 1 FOR THE CALL Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LEWALD December 2004 THOMAS W. LEWALD 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Buffmore
It Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Month, Day, Year)
Nov. 10, 1932 topkines n/a Hospita 7. Age (In yrs. last birthday) 5. Social Security Number Funeral A. Sex 9. Birthplace (State or Foreign Months 1☐M 2☐ F 72 Mary land 217-26-7892 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland aneat of Health and Mental Hygiene.
ant: If item 27 is marked other than "neturel; or Items 236 or 28a-f show thy or other traumatic event, Ire Modical Exertile manual to netiting at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or Items 23s or 28a-f shov other traumatic event, it a Modical Exertiner must be notified at 1 Yes 2 No Director Md. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1405B Bonnett Place 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status ZYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) years internal revenue agent federal government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry J. Lewald, Sr. Sarah Durry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1405B Bonnett Place, Bel Air, Md. 21015 Joan M. Lewald/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Parkwood Cemetery 12/30/2004 Baltimore, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 21014
ter the mode of dying, such as cardiac or respiratory arrest.

Approx 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Respiratory Immediate Cause (Final Physician Distress weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Directo for as a nonsecuence offcause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Embolus 1 Yes 2 No 3 Probably 4 Unknown Be Completed Colon cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo ၀ 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 5 Pending after death. death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 December 27 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabet Baltimore, MD 21287 600 N. Wolfe St 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 0 4 2005

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certification	e of Death	Reg	2004	42161
	Physic	an	1. Decedent's Name (First, Middle, Last)  CUDICTINE ADDIE UDICUE		2. Date of Death Month	Day Year 30, 2004	3. Time of Death
	/Medi	cal	CHRISTINE ADDIE WRIGHT  4a Fecility Name (If not institution, give street and number)	4b. City, Town, or L	DECEMBER	4c. County of Death	9:35am
	Examir	ier	5821 QUEENS CHAPEL RD.	HYATTSVII		PRINCE GEO	RGE
	Funeral Director		220-70-3150 1 M 2 T 88 Yrs. Months	r 1 Year If Under 24 Hrs.  Days Hours Min.	8. Date of Birth (Month, Day, Y		lace <i>(State or Foreign</i> try) CAROLINA
	land Dw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10	Od. Inside City Limits
	ath with the Marylar 23a or 28a-f show wat be notified at	ţō	MD. PRINCE GEORGE HYATTSVILLE				1 X Yes 2 □ No
	th the	irec	10e. Street end Number 10f. Zij	Code	10g	. Citizen of What Coun	try?
	23a vi	교		0725		USA	
020	72 hours after death with the Maryland natural', or Items 23e or 28e-f show Iteal Examinen inust be notified at	by Funeral Director	1 □ Never Married 2 □ Married   1 □ Yes 2 ☒ No	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2 No Specify:	ecity Yes or No- Rican, etc.)	14. Race - America Black, White, e	etc.
Maryland 21215-0020	c • 6	Completed	Elementary/Secondary (0-12)   College (1-4or 5±)	al Occupation rk done during most of work se retired)	ing 16	b. Kind of Business/Ind	ustry
121	led wi lygien ner th	5	-122- HOMEMAKE	1		HOUSEWIFE	
anc	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	Be	17. Father's Name (First, Middle, Last)  MANNING WILLIAMS	18. Mother's Nam	e (First, Middle, Ma 모습으로만	iden Surname)	
Ž	should ad Me mark matic	ဥ		(Street and Number or Rui		lifty or Town State 7in	Code
× ×	nd 2 salth ar 27 is r trau	- 1		JST RD. NW WA			5000)
ore,	es 1 a of Heginitem		20a. Method of Disposition 20b. Place of Disposition (National Computers, com	ne of	Date 20	c. Location - City or Tox	vn, State
im	Page ment (		4 Donation 5 Other (Specify)  DRUID RIDGE CI	EMETERY 1	-4-2005 B	ALTIMORE,	MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.		21. Signature of Fundral Service Licensee JONATHAN D. HIBNER Name and 1721-21	nd Address of Facility PHI N. MONROE S			
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mod shop, or heart failure. List only one cause on each line.	le of dying, such as cardiac	or respiratory arrest	•	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition a ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS as ISCHEMIC HEART DISEAS AS				Onset and Death
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	rtificate be executed ng physician and s as the burial-transit	edicai Examiner	Sequentially list conditions,    Sequentially list conditions,   Due to (or as e consequence of):			-	
68760,	sician buria	Na E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
	ifficate g phy as the	edic	resulting in death) Last  Due to (or as a consequence of):				
Вох	eath cert attendin I for use	an/M	d				
	e dea the att hed fo	Physician/I	Part II. Other aignificant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23b. Did toba	cco use contribute to	the cause of death?
P.0	es that the de igned by the a be detached f				1 ☐ Yea	2□ No 3□ Prob	ably 4 2 tonknown
of Vital Records,	requires been sign should be	Completed by			24a. Was an a performed	i? avai	re autopsy findings ilable prior to ipletion of cause
Re	The law ate has page 2	d mo			1∐ Yes	/	éath? Yes 2⊞No
ital			25. Was case referred to medical	26. Place of Deatl	h (Check only one)	245140	165 215 140
<b>_</b>	S S	To E	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC	Othor	me 5 Hesidence	e 6 □Other (Specify)	
n O	E E			Work?	28d. Describe how i	njury occurred	
Division	or Attending later death. Director: After	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined 28e. Place of Injury - At home, farm, street, factory	1 Yes 2 No	29f Location (Stree	t and Number or Rural	Pouto Atumbor
Diγ	after after Direc d in by	Certification:	4 Homicide determined building, etc. (Specify)	, ornice	City or Town, S		noute (variber,
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier  (Check only one)  1 □ Certifying Physician: To the best of my knowledge, death occurred a 2 □ Medical Examiner: On the basis of examination and/or investigation, and manner stated.	et the time, date and place, in my opinion, death occurr	and due to the caus ed et the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
	To the within 2			. License number	29d.	Date signed (Month, D	ay, Year)
			mano. veltzu	D23743		1-4-2005	
	a		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	•			
	*		MARTIN WELTZ 7525 GREENWAY CT. DR. GREEN 31. Date filed (Month, Day, Year)    182. Registrar's Signeture   183.	BELT, MARYLAI	ND 20770		
	Stat Registra	G	31. Date filed (Month, Day, Year)  32. Registrar's Signeture				

DHMH 16 Rev 6/95

		1	For State Registrar	State o	f Marylan		rtment of		nd Mental Hy	/giene Reg. No.	2004	42162
		.00	Decedent's Name (First, Middle,	Last)					2. Date of D	eath Day	/ Year	3. Time of Death
Phys	sicia edica		Helen E. W	eems					Decemb	er 2	9 2004	
Exa	mine	er	a. Facility Name (If not institution,			,		or Location of	Death	1 -	County of Death	
		7,7	Genesis Elder  5. Social Security Number	Care S	pa Cre		Anna pe		4 Hrs. 8. Date of Bi	irth	ne Aru	
Fune Direct			217-32-7999	1 □ M 25€	96	Yrs.	Months Day	s Hours	Min. (Month, D Nov. 3	ay, Year)		nplace (State or Foreign untry) Vland
pu ,		-	Usual Residence of Decedent		100 Cib	y, Town or Lo	ation					10d. Inside City Limits
laryla ahov		-	10a. State 10b. County									12 Yes 2 No
the M		Z -	Iaryland Anne	Arundel	An	napol	1.S 10f. Zip Code			10a. Citi	izen of What Cor	untry?
death with the Maryland ms 23e or 28a-f show				_								
death		Funerai	117 Victor Pa 11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V	Vas Decedent of	Hispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Amer Black, White	
36 after or ite			1 Never Married 2 Marrie	od 1 ☐ Yes If Yes, Gir	2 [X]No ve		☐ Yes 2℃N					lack
17215-0036 within 72 hours after ene. than "natural", or ite		ed by	3√∰Widowed 4 ☐ Divorced  15. Decedent'	Year or D	ates:	16a Deced	ent's Usual Occ	unation		16h Ki	nd of Business/I	ndustry
215 Jin 72 n na	100	Completed	(Specify only highest Elementary/Secondary (0-12)			(Give	kind of work don OO NOT use reti	e during most of	of working	100.11	ing of Buomiosari	
212 d with giene		E	3rd	College (	0		D	omesti	С	Pr	ivate	Family
laryland 21215-0036 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is marked other than 'natural', or Itema 23e or 28a-1 show aumatic event. It a Medical Examiner matter to notified a		Be	17. Father's Name (First, Middle, L	ast)					s Name (First, Middle		Sumame)	
aryla should and Men marke		ှ	John W. Po			10h Mailie	- Address /Ctm	1	ice Jone		Town State 7	in Code)
>			19a. Informant's Name/Relationsh Gloria Smith		orl				way Anna	-		12.5
Hear Hear		1	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other p		Date	,*	ocation - City or	
altimore, rmil. Pages 1 ar partment of Hea portant: If item?			1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		State		N CEMETI		-7-2005	BALT	TMORE: N	MARYLAND
Baltimol permil. Pages Department of Important: If i	9		21. Signature of Funeral Service L	icensee LARR					WM. REESE	& S	ONS MOR	TUARY, P.A.
<b>0</b> 88 <b>5 8</b>	Я		Lovy S. T		1483				NNAPOLIS,		LAND 214	
95.	, II		23a. Part1. Enter the disease, or shock, or heart failure. List of			h. Do not ente	er the mode of d	ying, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Pnysici /Medic			Immediate Cause (Final disease or condition resulting in death)	a			nutin					2yr
Examin				Due to	(or as a conseq	uence of):						•
25 1		Jer	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	uence of):						
cuted		Exan iner	Cause (Disease or injury that initiated events	c								
8760, rate be executed hysician and the burial-transit			resulting in death) Last	Due to	(or as a conseq	uence of):						
68760, filicate be execute physician and stibe burial-trans		dicai		d								
BOX 6. Geath certific death certific e attending pod for use as		Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		)			:	23d. Date of deli	very
. 0 0 0		sicia	in the past 12 months? 1 ☐ Yes 2 ➡No		birth 2 ☐ Feta nant at time of d		Ectopic pregnar Other (specify)	icy			Month	Day Year
Records, P.O. I The law requires that the de tte has been signed by the a		Phys	9 Unknown			Ini '- 45			aza Did	tobo soo .	an contribute to	the cause of death?
ires the signed		ğ	Part II. Other significant conditio	ns contributing to d	eath but not res	uiting in the ui	iderlying cause	given in Part I.			_	babiy 4 Unknown
Cord  * require  been significant  should be		etec							24a. Wa		•	topsy findings available
Division of Vital Records, to attending Physicien: The law requires the death.  Director: Alter this certificate has been signed in by the tuneral director, name 2 should he of		Completed							auto	opsy formed?	prior to c death?	ompletion of cause of
		0	25. Was case referred to medical					26. Place of	1 ☐ Yes of Death (Check only	2 No	1 Yes	2 No
f Vinysici		ToB	examiner? 1 ☐ Yes 2 ► XD	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	t 3 DOA	Other: 4 Nurs	sing Home 5 Res	idence	6 ☐Other (Spec	ify)
ng Pt		:io	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	W		28d. Describe	how injur	y occurred	
Oivision or Attending latter death. Director: After in by the funer		cati	2 Accident Investig	ot be as Bloom	e of Injury - At he	omo torm etc		□Yes 2□N		/Street an	d Number or Ru	ral Route Number,
Div lor A after Direction		Certification:	4 Homicide determi	ned 289. Flact	ling, etc. (Specif	y)	sec, lactory, offic		City or To	wn, State	)	an note willow,
Division of Vital To the Hospital or Attending Physicien: within 24 hours after death to the Funeral Director. After this certifical completely tilled in by the funeral director.		a C							place, and due to the			
he Ho in 24 he Fu		edical	(Check only 2 Medical form)		ner stated.	ition and/or in			n occurred at the time			
To the within 2 To the complete		Σ	29b. Signature and title of certifier	111.				3)636		29d. Dat	te signed (Month	**
h			// W				-	77656	5	/	/5/2W	3
3			30. Name and address of person	who completed cau	se of death (Iter	1) (Type.	Print)	. Ch	. L. Mo	2	1619	
	Stat	е	31. Date filed (Month, Day, Year)	32.	Degistrar's Signa	iture		-	1 /		*	
Reg	jistra	ar	JAN 0	6 2005	ogistrar's Signa	15 P	25450					<del></del>

			For	State of M			alth and Mental H	lygiene 200L	42163
			State Registrar		Ce	rtificate of De		Heg. No.	14100
	Physicia	an	Decedent's Name (First, Middle, L.				2. Date of Month	Death Day Yea	
	/Medic	al	Mimi	Blust		45 City Taylor and a	Decem		
	Examin	er	4a. Facility Name (If not institution, gr			4b. City, Town, or Lo		4c. County of De	
	Euparal		Wilson Health C  5. Social Security Number 6.		ge (In yrs. last birthday)		f Under 24 Hrs. 8. Date of	Montgon	inhplace (State or Foreign
	Funeral Director		183-05-0180	1 ☐ M 2 🖾 F	94 Yrs.	Months Days I	Hours Min. (Month, Dec.	Day, Year)	Country) France
	pc ,		Usual Residence of Decedent		do Co T				1011111111111
	anylau shov	2	10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	the M	Director	Maryland   Montgor	nery	Montgom	ery Villag	e	10g. Citizen of What (	
	with with the sor								Country ?
	ns 23	Funeral	19810 Greenside 7	12. Was Decedent	Ever in U.S. 13.	20886 Was Decedent of Hisps	anic Origin? (Specify Yes or	No- 14. Race - Ar	nerican Indian,
ယ္	after dea or Items		1 Never Married 2 Married	Armed Forces	? INo	If Yes, specify Cuban, I	Mexican, Puerto Rican, etc.)	Black, Wi	nite, etc.
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or Items 23a or 28e-f show event, Ite M. Jirel Ess nit et mant te notillied at	d b	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No 🥄	Specify:	Specify: V	Nhite
5-0	72 h	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	(Give	dent's Usual Occupation kind of work done duri	on ing most of working	16b. Kind of Busines	ss/Industry
121	within ane. then	d L	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired)		Own Hor	
d 2	filed withi Hygiene. Sther ther		17. Father's Name (First, Middle, Las	<u>4</u>	H(	ousewife 18	B. Mother's Name (First, Mid		ne
an	ld be ental ked o	To Be	William	Muff			Kati	e Unknown	1
Maryland	2 should be filed vor and Mental Hygie is marked other fraumetic event, II.	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street and	d Number or Rural Route Nu		
Ž	alth a		Nancy Blustein/Da	aughter	19810	Greenside	Terrace, Mor	ntgomery Vil	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumetic evonce.	1 8	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	□Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City	or Town, State
Ĕ	Pag ment ant: I		`4 □Donation 5 □ Other (Spec		Roosevelt	Mem. Park			PA.
3alt	ermit. Depart De		21. Signature of Funeral Service Lice	0 (	LXLL		of Facility DeVol Fu		
	70 = e d	$\square$	Office Posts States the disease of	Ju			Park Dr., Ga		MD. 20877
			23a. Part1. Enter the disease, or conshock, or heart failure. List onto	y one cause on each	line.	ter the mode of dying, s	such as cardiac or respirator	y arrest,	Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a		nonia	•		
	Examiner			Due to (or as	s a consequence of):				Weeks
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequence of):				
	outed nd ransit	Examiner	that initiated events	C					
0,	be executed sician and burial-transit		resulting in death) Last	Due to (or as	s a consequence of):				
8760,	ate the	dlcal		d					
9	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome	e of pregnancy			and Date of	I-15
Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of o Month	lelivery Day Year
o.	that the de led by the a detached t	yši	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown					
٦.	es that igned b be deta	by Pł	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause given	in Part I. 23e. D	id tobacco use contribute	to the cause of death?
Records,	quire an sig uld bu	ed b					1	☐Yes 2☐No 3☐	Probably 4 Donknown
000	ie law requ has been ge 2 shouk	plet					24a. W		autopsy findings available o completion of cause of
Œ.		Completed					po 1 ☐ Ye	erformed? death	7
Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	Hannital.			6. Place of Death (Check on	ly one)	
of	or Attending Physician: after death. Director: After this certifici in by the funeral director, in	၉	1 ☐ Yes 2 ☑ No  27. Manger of Death	Hospital: 1  Inpat			4 Nursing Home 5 ☐ R	esidence 6 Other (Sp be how injury occurred	pecify)
	ding h. h. After funer	tlon	1 ☑Natural 5 ☐ Pending	(Month, D	ay Year) Injury	Work?	s 2 No	oe now injury occurred	
Division	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not	be 2Be. Place of Ir	njury - At home, farm, st	reet, factory, office	28f. Locatio	n (Street and Number or	Rural Route Number,
ă	al or after	Certification:	4  Homicide	building, e	tc. (Specify)		City or	Town, State)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer						date and place, and due to tion, death occurred at the tin		
	the H in 24 the F the F	Medical	one)	and manner s	tated.				``
	To To con	2	29b. Signature and title of certifier	110	1	29c. License n	20148	29d. Date signed (Mo	( )
	10			1 Joan	doub (la contra	Deien)	20110		16,2004
	( )		Steven 1)	olinsky M	·-		11 Ave. G	althersburg	.md.
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 20 2		trar's Signature	Sparks	/		

			1- For State of Maryland / Dep Registrar Ce	artment of Health and M <i>rtificate of Death</i>	ental Hygie Reg.	2004	42164
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Marjorie Ann Backus		December	<u> </u>	1:55 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
п			Suburban Hospital	Bethesda		Montgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
ı.	Director		377-10-0943 85		Aug. 22,	1919   Mary	land
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L.	ocation		1	0d. Inside City Limits
	Mary f sho	ō					1 ☐ Yes 2 🕱No
	28a-	Director	Maryland Montgomery Betheso	da. 10f. Zip Code	10g.	Citizen of What Cour	ntry?
	3a of		9707 Old Geortgetown Road, Apt. 153	_		USA	
	death with the Maryland ms 23a or 28a-f show criust be nutified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Americ	
_	after or Ite		Armed Forces?  1 □ Never Married 2 □ Warried 1 □ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White,	
2-003B	hours after tural', or Ite	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whit	e
ဂ ဂ	be filed within 72 hours after death with the Marylan ital Hygiene.  and atther than "natural", or liems 23a or 28a-f show and other than "natural", or liems 23a or 28a-f show event, it is Madical Examiner must be nutilised at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working	16b	. Kind of Business/Inc	dustry
N	within 72 ene. than "na!	du	Elementary/Secondary (0-12) College (1-4or 5+) life.	DO NOT use retired)			
N	se filed within all Hygiene. I other than " went, I're Ma			emaker		Own Home	
and	be fill tal H od otl	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	,	
Ž	2 should be finance and Mental Finance of its marked of raumatic ever	٢	William Franklin Estes		cretia H		20017
Z Z	nd 2 sh ith and 27 is n traun			ing Address <i>(Street and Number or Rura.</i> Old Georgetown Roa			•
e,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 20b. Place of Disposition cometary, cre		ate 20c.	. Location - City or To	wn, State
aitimor	Pag ant: If		1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Metropolit	α ·		exandria,	Virginia
ga	ermit. epart nport ny inj nce.		21. Signature of Euperal Service Licensee	2. Name and Address of Facility Francis J. Collins	Funeral	Home Inc	
_	<b>₽</b> □			500 University Blvd		ver Spring	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ARREST		3	0/11/
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	10000			
	_xammo	<b>.</b>	Sequentially list conditions,  b. Due to for as a consequence of:	ARTERY DISEA	SE		
	ed isit	iner	if any, leading to immediate Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury				
_	and and I-trar	Examin	that initiated events resulting in death) Last  c.  Due to (or as a consequence of):				
8/00,	cate be executed physician and the burial-transit						
20	ficate be executed physician and sthe burial-transit	edical	d.				
XO	certii nding ise a		IF FEMALE: 23b. Was decedent prognent 23c. If yes, outcome of pregnancy			23d. Date of delive	inv
Ď	death e atter ed for u	lcian/M	in the past 12 morans?	□Ectopic pregnancy □ Other (specify)		1	Day Year
j.	the d y the	hys	1 Yes 2 No 9 Unknown				
<u>,</u>	s that ned b deta	by PI	Part II. Dther significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?
coras	requires that the een signed by th hould be detache				1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
2	- Q 70	Completed			24a. Was an	24b. Were autor	osy findings available
Ď L	9 4 9	luc			autopsy performed	? death?	npletion of cause of
		Ö	25. Was case referred to medical	26. Place of Death	(Check only one)	1 ☐ Yes	2L No
>	Physicien: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ FNOutpatie	Other		a 6 ∏Other /Specifi	,)
		on: T	27. Manner : eath 1. 28a. Date of Injury (Month, Day Year)   28b. Time of Injury (Month, Day Year)   28b. Time of Injury	of 28c. Injury at 2 Work?	8d. Describe how in		7
S	teath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury. At home farm et	M 1 Tyes 2 No	106 1 101		10 11
DIVISION	or At after of Direct in by	Certification:	4 Homicide  determined  28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town, St	t and Number or Rura tate)	I Houte Number,
_	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal	th occurred at the time, date and place, a	nd due to the cause	e(s) and manner as st	ated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, L	
	G		20 Name and address of ages	102625		12/16	104
			30. Name and address of person who complete feature of death (Item 23a) (Type,	Print) 18 WISCONS	IN AL	E	
	Sta		31. Date filed (Month, Day, Year) PEC 20 2004  32. Pegistrar's Signature	local 1			
	Registr	ar	DLU & U 2004	pyours			

			For State of M	aryland / Dep <i>Ce</i>	ertificate of I	lealth and M D <i>eath</i>		enge () () (4	42165
	21		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		Olive Hope Baldwin				December		12:05pm м
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Aberde	Location of Death		4c. County of Death Harford	
-	Funeral			ge (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		184-07-7571 1□M 2ĂF	89 Yrs.	Months Days	Hours Min.	10/16/19	Mary	land
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Maryl -f sho	tor	Maryland Harford	Aberdee	en				1 XYes 2 □ No
	th the or 288	Director	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Cou	ntry?
	ath wi	raic	626 Cindy Court		21001			USA	
ထ္ဆ	filed within 72 hours after death with the Maryland Hygiene. Sther then "neturel", or Items 23e or 28e-f show ent, the Medical Examinar must be notified at	/ Funerai	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes, Give	?	. Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 □XNo	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
21215-0036	hours turet',	ed by	3. Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education	16a Dec	edent's Usual Occup		16	Sb. Kind of Business/Ir	
7	in 72 n "ne Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Giv	e kind of work done of DO NOT use retired	during most of working	ng	DD. Kille of Desillessyn	idustry
2	ed with	Com	12 4		ne maker			in home	
Maryland	htal H	Be	17. Father's Name (First, Middle, Last)  Albert T. Ewing			18. Mother's Name Maude	<i>(First, Middle, Ma</i> E <b>.</b> Strim		
ž	should nd Mei mark imatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street			City or Town, State, Zij	Code)
	alth ar alth ar 27 is ar treu		Sharon B. Moxley (daughter		Cindy Cou				,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other treumetic event, the Medical Examinar must be notified at once.		20a. Method of Disposition  1	20b. Place of Disp cometery, cre Harford N	position (Name of ematory or other place Memorial G	ardens 12	ate 20 /28/04 A	oc. Location - City or Toberdeen, M	own, State aryland
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	lesber 7	farring^ca Aberdeen,	rgo Funer Maryland	al Home, 21001-33	P.A. 99	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each t	d the death. Do not er	·				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Partinson	is Discas	se			Onset and Death
ı	/Medical Examiner		Due to (or as	s a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate  Due to (or as	s a consequence of):					
	rcuted nd transit	Examiner	cause. Enter Underlying Cause (Liscass of Figur) that initiated events c.						
58760,	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (or as	s a consequence of):					
687		edical	d						
Вох	eath certif attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		□Ectopic pregnancy			23d. Date of deliv	*
P.O. E	or Attending Phystcian: The law requires that the death certifute death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Physiclan/M			Other (specify)			Month	Day Year
	wrequires that the d been signed by the should be detachad	by Ph	Part II. Other significant conditions contributing to death l	out not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ğ	equire en sig ould b						1 🗌 Yes	2. Prot	pably 4 Unknown
Records,	ne law n has be ge 2 sh	Completed					24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
alF	ysician: The is certificate hadirector, page							No 1 ☐ Yes	2 No
₹	ysicial Is certii directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣ No Hospital: 1 ☐ Inpati	ient 2 ER/Outpatie	ent 3 DOA Oth	26. Place of Death er: 4 □ Nursing Hon		ce 6 Other (Special	(v)
10	ding Phy n. After thi funeral o	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Da	urv 28b. Time	of 28c. Injury		8d. Describe how		,
Sio	r Attendir er death. rector: Af by the fu	catic	2 Accident investigation		M 1	Yes 2 □ No			
Division of Vital	Hospital or Attand 24 hours after deatl Funaral Director: tely filled in by the	Certification:	determined 286. Place of In	ijury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office	1	City or Town,	et and Number or Rura State)	al Houte Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or i	ath occurred at the tin investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cau od at the time, date	se(s) and manner as s o and place, and due to	tated. o the cause(s)
	To the comp	Ž	29b. Signature and title of certifier	0	29c. License	148050		1. Date signed (Month,	Day, Year)
ı			peoples ohull m	da a the (th		10030			
	12		30. Name and address of person who completed cause of Prashant Shukla M.O. 15	S. Parke S		Aberdee	nmp 21	1001	
	Sta		31. Date filed (Month, Day, Year)  32. Regist	rar's Signature	1 '				
	Registr	ar	DEC 2 2 2004	Even St.	Cools				

			1 - For State of Maryland / Department	artment of Health and Me		2004 42166
	ō		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Į.	Physici /Medic		Robert A. Boisseau, Jr.	]	Month December	16, 2004 1715 M
}	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Johns Hopkins Hospital	Baltimore		
	Funeral Director		5. Social Security Number  228-58-8210  Usual Residence of Decedent  6. Sex 1 M 2 F 60  Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	3. Date of Birth (Month, Day, Y.) 1-2-1944	ear) 9. Birthplace (State or Foreign Country) Georgia
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Many F-f sh	tor	Maryland Anne Arundel Annapol	is		1 ☐ Yes 2 X No
	or 28s	Funeral Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	23a	ral	1843 Brett Ct.	21401		USA
	tams	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fi	1 Never Married 2X Married 1X Yes 2 No	1 ☐ Yes 2∰No Specify:		Specify: White
<del>o</del>	hour htural	ed t	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	b. Kind of Business/Industry
7	within 72 hours after death with the Maryland one. than "natural", or Itams 23a or 28a-f show than "natural", or Itams 23a or 28a-f show the Modical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0·12) College (1·4or 5+)	kind of work done during most of working DO NOT use retired)	7	o. rand of Basinossy illustry
21215-0036	d with giene er tha	mo:	, , , ,	nalyst	D	epartment of Defense
힏	al Hy al Hy fothe vant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (		
Maryland	should be filled withind Mental Hygiene. s marked other than umatic evant, Its M	To	Robert A. Boisseau, Sr.			l Tucker
<u>Ja</u>	2 sho			ng Address (Street and Number or Rural		
	1 and 2 Health am 27 sthar tr			Brett Ct., Annapol:		
altimore,	of of		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State	matory`or other place)		c. Location - City or Town, State
≣	permit. Pag Department Important: I any injury o		'4 □ Donation '5 □ Other (Specify) Kalas Cr 21. Signatur of Funeral Service Licensee			dgewater, MD
Ba	permit. Departr Import. any inj		noun o lucio 2	2. Name and Address of Facility Geor 1973 Solomons Island	d Rd. Ede	gewater, MD 21037
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  aANOXIC BRAIN	INJURY		FOUR DAYS
В	/Medical Examiner		Due to (or as a consequence of):			
		-a	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause that Underful Cause (Disease or injury that initiated events			
Ć	execting and and rial-tra	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	rate be executed obysician and the burial-transit	dical	d			
9	rtifica ng ph as th	Medi	IF FEMALE:			
Вох	leath certifica attending pt I for use as t	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of delivery
	e dea the at ned fo	sici		Other (specify)		Month Day Year
0	that the de led by the a detached t	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	andarhing anyon gwan in Part I	23a Did tabaa	co use contribute to the cause of death?
Division of Vital Records,	eg Ded	d by	CORONARY ARTERY DISEASE	niderlying cause given in Facts.	1 Yes	_/
Ö	w requir been si should	Completed	ALL CHE			
Rec	has has	ld m			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
g		e Co	25. Was case referred to medical	OR Plant of Partle	1 ☐ Yes 2 ☑	
=	ysician: Is certific director,	o B	examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatien	26. Place of Death (		e 6 □Other (Specify)
o	g Phys er this eral di	n: T	27. Manner of Death 28a. Date of Injury 28b. Time o		d. Describe how i	
Ö	Attending Physician: or death. sector: After this certifice by the funeral director.	atlo	1 ☑ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No		
<u>≥</u>	or Attencafter death	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28	f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	ital or irs afte ral Dir led in	Cer				<u> </u>
	To tha Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deatled the basis of examination and/or in and manner stated.	h occurred at the time, date and place, an vestigation, in my opinion, death occurred	d due to the caus at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To tha within 7 To tha comple	M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
)			Advan Sallel Malik, MEDICAN DOCTOR	RES-000	00	ELEMBER 16, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, ADNAN MALIK, 600 NORTH WOLFE ST	Print)	1ARYLAN	10 21287
*	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 0 2004  32. Registrar's Signature			
		-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 U Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December 26, 2004 **Physician** 0918 Kenneth Barry /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | 8/28/34 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Country) 1**⊠**M 2□ F Months 70 205-24-8611 Pennsylvania Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Aberdeen MD Harford 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21001 406 Lorraine Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 (\$\forall Yes 2 □ No If Yes, Give 1 955-57 Year or Dates 1 Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Ite 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mortician/owner Funeral Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caroline Mathiott Merrill Cargo, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Lorraine Street Aberdeen, Maryland 21001 Norma P. Cargo (Spouse) any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 反 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/3/05 Spesutia Cemetery Perryman, Maryland 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Houn Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2₽No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an -argo, Kenneth Yes 2 - NO 25. Was ca examiner? modularys To the Hospitel or Attending Physician: within 24 hours after death. 26. Place of De at 1 Check only one Hospital: Inpatient Other: 1 🗌 Yes 2-No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address

person who

Day, Year)

cause of death (Item 23a) (Type, Print)

		×	1 - For State Registrar	State of	Marylan				lealth a Death			Reg. No.		42168
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Ruth H. Culp     4a. Facility Name (If not institution,		er)		4b. City	Town, or	Location of	Г	2. Date of De. Month December	Day 17.	Year 2004 County of Death	3. Time of Death 8:30 <sup>P</sup> M
	Funeral Director		332-30-0722		Age (In yrs.	last birthday) 92 Yrs.	Si If Unde Months	lver S 1 Year Days	Pring If Under 2 Hours	Min.	B. Date of Birt (Month, Da Oct. 3,	h y, Year)	Cot	y nplace (State or Foreign intry)
	the Maryland 28a-f show	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo  10e. Street and Number	mery		ly, Town or Lo	ring	Code				10g. Citi	zen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itame 23e or 28e-f show any injury or other traumatic event, the Medical Exatt in a minite multied at ODGe.	by Funeral DI	1125 Cresthaven I  11. Marital Status  1 Never Married 2 Married 3 Married 4 Divorced	12. Was Decede	es? [ <b>3</b> tNo		Was Dece	cify Cuba	ispanic Orig in, Mexican, Specify:	in? (Speci Puerto Ri	ify Yes or No ican, etc.)		USA 14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	ad within 72 horgiene. ar than "naturit, the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4	or 5+)		dent's Usu kind of wo DO NOT u	ork done d se retired	during most ()	of working	7	16b. Kii	nd of Business/I Educa	
Maryland	should be file and Mental Hy s marked oth umatic event	To Be	<ul><li>17. Father's Name (First, Middle, L.</li><li>John A. Hoefer</li><li>19a. Informant's Name/Relationshi</li></ul>		······································	19b. Mailir	ng Addres	(Street a	Hilo	da Holl			Sumame) r Town, State, Zi	ip Code)
altimore, M	Pages 1 and 2 ant of Health at: If Item 27 is y or other tra		Joan Carol Poor/Da  20a. Method of Disposition  1  Burial 2  Coremation 3  4  Donation 5 Other (Sp.	Removal from St	ate	9112 Place of Disponentery, cremetery, cremetery	nsition (Na matory or	me of other plac		College Dai Decembe 2004	te		cation - City or T	
Baltii	permit. F Departme Importar any injur		21. Signature of Funeral Service Li	Carriel	4	<b>F</b> f 50	2. Name a rancis 00 Uni	J. Co versi	ss of Facility Ollins ty Blvd	Funera	al Home Silver S	Inc.	kandria, M	01
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Respi	iratory as a conseq	Failure uence of):				arulae or i	espiratory ar	rest,		Approximate Interval Between Onset and Death
. Box 68760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No	d	n 2 ⊡Feta itattime ofd	ancy	□Ectopic p					2	23d. Date of delive Month	very Day Year
s, P.O	es that the igned by th be detache	by	9 Unknown  Part II. Other significant condition  Chronic Lung Diseas		th but not res					xđ				the cause of death?
al Reco		Completed	Femoral Hernia								,	rmed? 2 No	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
Division of Vital Record	ding Phys h. After this funeral di	atlon; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga			ER/Outpatier 28b. Time of Injury		28c. Injury Work	er: 4 □ Nur:	sing Home	Check only o	dence 6	Other (Speci	(fy)
Divis	spital or Attendon's after death ours after death neral Director: filled in by the	al Certification:	3 Suicide 6 Could no determine 4 Homicide 29a. Certifier 1 Tactifying	286. Place 0	, etc. (Specif				ne, date and		City or Tox	vn, State)	)	rai Route Number,
•	To the Hospital or vithin 24 hours after To the Funeral Director completely filled in b	Medical	(Check only 2 Medical E	Raminer: On the bas and manner	s of examina	ution and/or in	vestigation 29	c. License	oinion, death	h occurred	at the time,	date and 29d. Date	place, and due to e signed (Month, mber 18,	Day, Year)
	برات Sta	ite	30. Name and address of person we George Flening Se	ngstack, M.D.	of death (Item 3939 F	'errara [	Drive,			20906	5			
	Registr	ar	DEC 20	2004   🔑	mercar	Ø	100	atte						

			1 - For Amend It	em #23 c-c 23pt.I	of Ma 1&25 I	ryland/Dep per me G8 Ce	artment of britificate of			lental Hy	giene	104	42169
	Division		1. Decedent's Name (First, Mic	ddle, Last)						2. Date of De	eath	.,	3. Time of Death
	Physic /Medi		Mary Ann Cole	man						Decem	Day Q	Year 2004	0-730 MT
3	Exami		4a. Facility Name (If not institut	tion, give street and	number)		4b. City, Town, o	or Location	of Death			ty of Death	
			Washington Co					stown			Wasl	ningtor	1
	Funeral Director		5. Social Security Number 218-56-2548 Usual Residence of Decedent	6. Sex 1 ☐ M 2 <b>X</b> F	_	55 Yrs.	Months Days		Min.	8. Date of Bir (Month, Da October	ay, Year)	9. Birthplac Country Washin	gton, D.C.
	land ow		10a. State 10b. Cour	nty		10c. City, Town or Lo	ocation					100	I. Inside City Limits
	the Marylan r 28a-t show	ţo	Maryland Wash	ington		Hagerstow	n						1 Yes 2 □ No
	or 28a e reti	Director	10e. Street and Number	<u> </u>		8	10f. Zip Code				10g. Citizen of	What Country	/?
	th wit	a D	1500 Pennsylva	nia Avenu	e		2174	42			П.	S.A.	
	Items Der mi	Funeral	11. Marital Status	12. Was D	ecedent 8 Forces?	Ever in U.S. 13.	Was Decedent of H	Hispanic O	rigin? (Sp	ecify Yes or No	)- 14. Ra	ice - American	Indian,
36	ours after death v al', or Items 23a Eranicer munt	J.	1 Never Married 2 M	arried 1 TYe	s 2 1 N	lo	1 ☐ Yes 2 🙀 No			riicari, etc./	Speci	ack, White, etc	
8	2 3	d by	3 □ Widowed 4 🙀 Divord	ed Year o	r Dates:							MILL	
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a	should be nd Mental marked ( imatic ev	To B	Joseph S. Mide	dleton				Shi	rlev	Ann Mi	ller		
Maryland	s 1 and 2 should f Health and Mer itam 27 Is marke othar traumatic		19a. Informant's Name/Relation	nship (Type, Print)		19b. Maili	ng Address (Street	· · · · · · · · · · · · · · · · · · ·				, State, Zip Co	ode)
	alth alth 27 ls		Joseph Middle	ton/Brothe	er	2406	Elsworth	Way	#3A,	Freder	ick, Ma	ryland	. 21702
Baltimore,	of Hea of Hea fitam rotha		20a. Method of Disposition			20b. Place of Dispo	sition (Name of natory or other pla	_		Date		- City or Town	
Ē	Pag ent nt: i		1 🙀 Burial 2 □ Crematio 4 □ Donation 5 □ Other		m State	Mt. Olive		· 1	/3/2	005	Frederi	ck. Ma	rvland
alt	permit. Departm Importa any nju		21. Signature of Funeral Servi	ce Licensee	-11	. 22	2. Name and Addre						hurch Street
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i			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that ist only one cause of	it caused n each Jin	the death. Do not en	er the mode of dyir	ng, such as	s cardiac o	or respiratory ar	rrest,	A In	pproximate iterval Between
盟	Physician	0.00	Immediate Cause (Final disease or condition	Real	ara	tour Far	Mal					0	nset and Death
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٢	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due	o (or as a	consequence of):	<del>`</del>		CERT	FICATION APPRI	OVED BY FEDICA		the
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Вох (	death certifica e attending ph id for use as tl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome o	of pregnancy					23d Ds	ate of delivery	
ă	death a atte	clai	in the past 12 months?				Ectopic pregnancy Other (specify)	У				onth Da	y Year
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ο,	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant cond		death bu	t not resulting in the u	nderlying cause giv	en in Part	l.	23e. Did to	obacco use con	tribute to the o	cause of death?
rg	w require been sig should b	edi	Multiple scle	rosis						1 U Y	∕es 2□No	3 🗌 Probabl	y 450Unknown
of Vital Records,	has be pe 2 sho	Completed								24a. Was		Were autopsy	findings available
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ita	Physician: Th this certificate ral director, pag	Bec	25. Was case referred to medi examiner?	cal				26. Place	e of Death	(Check only o			3 110
<u></u>	Physic this ce al dire	To F	1 X es 2 X	Hospital:	Inpatier	nt 2 ER/Outpatier	t 3□ DOA Oth	ier: 4□Ni	ursing Ho	me 5 Resid	tence 6 □Ott	ner (Specify)	
Ē	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 XNatural 5 ☐ Pen	/1.4	te of Injur	Year) 28b. Time of Injury	28c. Injur Wor	y at k?		28d. Describe h	now injury occur	red	
sio	Attending r death. actor: After by the funer	catl		stigation				Yes 2□					
Division	or At ifter of Diract in by	Certification:	4 Homicide dete	mined 289. Pld	ce of Inju Iding, etc	ry - At home, farm, str . <i>(Specify)</i>	eet, factory, office		1	28f. Location (S City or Tow	Street and Numl vn, State)	ber or Rural Re	oute Number,
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	To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	edical	29a. Certifier 1 Certification (Check only 2 Medic one)	al Examiner: On the	ne best o basis of anner stat	f my knowledge, death examination and/or in-	occurred at the tire of the ti	ne, date ar pinion, dea	nd place, a ath occurr	and due to the d ed at the time, d	cause(s) and ma date and place,	anner as state and due to the	d. e cause(s)
	o the	Me	29b. Signature and title of certi		211101 3(4)		29c. Licens	e number			29d. Date signe	d (Month, Day	/, Year)
	F 5 F 0		▶ MOo	d) /			DI	1668	761		Dan	08	2004
•	2	ŀ	30. Name and address of person	on who completed ca	use of de	ath (Item 23a) (Type	Print)	TUS	0 1		ULC	d w	2001
	J		I Q O MT 31. Date filed (Month, Day, Yea	ACTUP	- 14	DM)	HAGO	NSN	WN	MD	21	740	١,
	Sta Registr	- 36	JAN (	· •	Elege	rs Signature  L	parke						

			For State Registrar				d / Depa		Health and N	Mental Hy	_	04	42170
	Physicia /Medic Examin	al	1. Decedent's Name Thorner 4a. Facility Name (li		S. give street and nu		efibaug		or Location of Death	2. Date of De. Month Dec 23,	2004	Year y of Death	3. Time of Death 5:30 am M
	Funeral Director		5016 Hai 5. Social Security N 214-07-3	mpden lumber 3731		7. Age (In yrs. 89	last birthday) Yrs.	Betheso ff Under 1 Year Months Days	la r If Under 24 Hrs.	8. Date of Bird (Month, Da Feb 12	Montg	gomer	y ace (State or Foreign try)
	ne Maryland 8a-f show	Director	Usual Residence of 10a. State MD	10b. County Alleg	any	10c. City	, Town or Lo LaVal					10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
0036	be filed within 72 hours after death with the Maryland nia! Hygiene. od other then "neture!, or Items 23e or 28e-f show event, the Medical Examiner, ust bancilified at event, the Medical Examiner.	by Funeral	10e. Street and Nur  10 Cash  11. Marital Status  1 □ Never Marri 3 □ Widowed	Valley  ed 2 Marri	12. Was Dec Armed Fo 1 Tyes If Yes, Gi Year or D	ve X No	1	□Yes 2 No		ecify Yes or No Rican, etc.)	14. Ra Bla Specii	SA ce - America ack, White, e	an Indian, atc.
Baltimore, Maryland 21215-0036	e filed I Hygi othar	Se Completed	Elementary/Seco	ndary (0-12)	t grade completed) College (			ent's Usual Occu kind of work done OO NOT use retire CONTO! IR	pation a during most of work ed)  1SPECTOR  18. Mother's Nam		16b. Kind of E  Ballistic  Maiden Sumai	s	ustry
Marylar	should and Mer a marke sumatic	ToB	Claren 19a. Informant's Na Mary Big	ame/Relations		h aughter		g Address (Stree	Jessie		r, City or Town	, State, Zip (	Code) 1D 20814
imore, I	Pages 1 and 2 nent of Health ant: if item 27 i		20a. Method of Disp	oosition Cremation	3 □Removal from	20b. P	L lace of Disposemetery, cren	sition (Name of latory or other pla neral Home	ace)	Date 12/28/2004	20c. Location	- City or Tov	
Balt	pernit. Pag Department Important: i any njury o		21. Sign dure of Fu	no	2/6	aused the death	4	108 Vir	ess of Facility Illi Funeral Ho ginia Avenue ing, such as cardiac	me, P.A. : Cumber	land, MD	21502	Approximate
9	Pnysician /Medical Examiner	-	Immediate Gause ( disease or condition resulting in death)	Final n	a. CONGI Due to	ESTIVE F (or as a consequence L FAILUE (or as a consequence	HEART I uence of): RE					3	Interval Between Onset and Death YEAR
68760, 4	te be ysicie	ical Ex	Sequentially list con it any, reading to im- cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	rlying injury ast	c	(or as a consequ	·						
P.O. Box 6	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2  9  Unknown	months?	1 Live b	tcome of pregna birth 2 Petaf nant at time of de own	death 3	Ectopic pregnand Other (specify)	гу			ate of deliver onth E	y Day Year
ords, F	w requires that been signed t should be det		Part II. Other signifi	icant conditio	ns contributing to de	eath but not resu	ulting in the un	derlying cause gr	ven in Part I.				e cause of death?
ital Rec	ician: The law certificate has b rector, page 2 s	e Completed	25. Was case refer	red to medical					26. Place of Deatl		sy med? 2 🐼 No	Were autops prior to com death?	sy findings available pletion of cause of
Division of Vital Records,	ng Phys fter this ineral di	Certification; To B	examiner? 1 Yes 2 4  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		ation ot be 28e. Place	of Injury th, Day Year)	ER/Outpatient 28b. Time of fnjury me, farm, stre	28c. Inju	her: 4 Nursing Ho iny at ork? Yes 2 No		ence 6 (X)th ow injury occur	red	nome
D		Medical Cer	29a. Certifier	1⊠ Certifyin 2  Medical I	Physicien: To the	best of my know	vledge, death	occurred at the ti estigation, in my	ime, date and place, opinion, death occurr	and due to the o	ause(s) and ma	anner as state	ted. the cause(s)
	To th withir To th comp	Me	29b. Signature and	title of certifier	, 1			29c. Licens	se number 025029	2	29d. Date signe	d (Month, D.	*
	(1) Stat Registra	te	30. Name and addle	Biggar,	1/12	of death (Item	Room	8014, 6	120 Execu	tive Blvd	l. Rockv	ille MC	)

		1	State of Maryland / Depart	tment of Health and M ificate of Death	ental Hygien Reg. No		42171
	2		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia		Roy Elmer Dwyer, Sr.		Month Da December 1	•	11:31 рм
	/Medic Examin			4b. City, Town, or Location of Death		c. County of Death	
	LXdiiiii		Holy Cross Hospital	Silver Spring		Montgom	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign
	Director		213-24-4133 1\(\overline{x}\)M 2□F 75 Yrs.	William Days Flours William			hington, DC
	p ,	<b>)</b>	Usual Residence of Decedent  10a State 10b County 10c City, Town or Loc	ation			10d. Inside City Limits
	anyla		10a. State 10b. County 10c. City, Town or Loc	alion			1 ☐ Yes 2 ☐ No
	8a-1	Director	Maryland Montgomery Wheaton	1	100 0	itizen of What Cou	
	death with the Maryland ms 23a or 28a-f show	声	10e. Street and Number	10f. Zip Code	10g. C	ILIZON OF WINAL COU	indy?
	s 23	era	12121 Valleywood Drive  11 Marital Status 12. Was Decedent Ever in U.S. 13. W	20906 as Decedent of Hispanic Origin? (Spe	cify Yes or No-	USA 14. Race - Ameri	ican Indian.
_	after death with the Marylan or Items 23a or 28a-f show rither ast be notified at	Funerai	11. Marital Status  12. Was Decedent Ever in U.S.   13. Was Decedent Ever in U.S.   14. Was Decedent Ever in U.S.   14. Was Decedent Ever in U.S.   14. Was Decedent Ever in U.S.   15. Was De	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
2-0036	hours after tural', or Ite	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: Sept. 1947	☐ Yes 2☑ No Specify:		Specify: Wh	ite
ş	2 hou	Completed	15. Decedent's Education 16a. Decede	int's Usual Occupation	16b. I	Kind of Business/Ir	ndustry
2	within 72 ene. than "nai	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give k life. D	ind of work done during most of workii O NOT use retired)	19		
7	d with	mo.		Employed	Н	obby Sho	p
<u> </u>	be filed within 72 hours after de ital Hygiene. Id other than "natural", or Items event, It'e Modical Exertinal.	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	n Sumame)	
/Ian	Menta Menta srked	70	Elmer Arthur Dwyer	Doroth	y C. Welsc	h	
<u>a</u>	and I	1.0	, , , , ,	Address (Street and Number or Rura	-		13
Σ.	and allth			l Valleywood Drive			
e e	of H		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, crem		ber 17	Location - City or T	own, State
Ĕ	Pag ment ant: I	1	`4 □Donation 5 □Other (Specify) Metropolitar	the second secon			, Virginia
Baltimore,	permit. Pages 1 and 2 should be filed with operation of health and Mental Hygien Department if item 27 is marked other through any injury or either traumatic event, ILS once.		21. Signature of Funeral Service License	Name and Address of Facility Incis J. Collins 1 00 University Blvo	Funeral Ho	me Inc er Sprin	g, MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or help failure. List only one cause on each line.	r the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Anoxic Encephalope	1 + hvz			Onset and Death
•	/Medical		resulting in death)  All OXIC ISINCEDITATORS  Due to (or as a consequence of):	City			7
	Examiner		Sequentially list conditions b. Respiratory Arrest				
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.				
	ocuted nd transi	Examiner	trat initiated events	e Pulmonary Disea	ise		
Ď,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760	ate b	dical	d				
Q X	death certific e attending p ad for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			Old Date of deli-	
Box	ath c attend for us	Physician/Me	in the past 12 months?  1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year
0	0 0	ysic	1 Yes 2 No 9 Unknown	Other (specify)			
٦.	de de		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Vital Records,	uires sign	d by	Congestive Heart Failure		¥∃Yes	2□No 3□Pro	bably 4 Unknown
Ö	w requ been should	Completed	Jongoverve mart rattage		24a. Was an	24b Were aut	opsy findings available
ě	The law cate has page 2.	mpi	Staphylococcal Septicemia		autopsy performed?	prior to co	ompletion of cause of
<u></u>			OF War and referred to medical	OO Diago of Docate	1 Yes 25 N	lo 1 Yes	2 No
Ĭ	Physician: r this certifica ral director, i	) Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other	n (Check only one) me 5□ Residence	6 □Other (Spec	ihr
ot	Phys r this ral di	.: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how inj		ny)
O	ttending P death. tor: After the funera	tior	1	Work? M 1 ☐ Yes 2 ☐ No			
Division of	Atter dea	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, stre	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rui	ral Route Number,
á	al or after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		Only of Town, Sta	10)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only (Check only 1) Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place,	and due to the cause(	s) and manner as	stated.
	he He in 24 he Fu pletel	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or invand manner stated.				
	To t To t	Σ	29b. Signature and time of certifier	29c. License number D52661	29d. D	Dogombox	
			Wan K. Legal ms	D32001		becember	16, 2004
	Let 1		30. Name and address of person who completed cluse of death (Item 23a) (Type, I	rint)			
		{ l	Alan R. Segal, MD. / 1517 Hugo C	ircle, Silver Spr	ing, MD 20	906	
					•		
4.0	Sta Registi		31. Date filed (Month, Day, Year)  DEC 20 2004  32. Registrar's Signature	Sporters			

			State of Maryland				-	_	
			1 - State Registrer	Cer	tificate of Dea	ath	Reg.	No.2004	42172
Н	Physici	an	1. Decedent's Name (First, Middle, Last)			ĺ	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Judy Gail Dodge  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loca		secember	4c. County of Dea	<del></del>
	Examin	er	Washington County Hospital		Hagerstow		,	Washingto	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year If L	Jnder 24 Hrs. g	B. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
	Director		215-44-5491 1 M 2 SF 57	Yrs.	,	J	une 28,1	947 Vi	rginia
	/land		10a. State 10b. County 10c. City, 7	Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	Maryland Washington Hag	gerst	own				1 ☐ Yes 2 ☐ No
	or 28	by Funeral Director	10e. Street and Number		10f. Zip Code			Citizen of What Co	,
	eath v	eral	20724 Oriole Circle  11. Marital Status  12. Was Decedent Ever in U.S.	13 \	21742	nic Origin? (Speci		ited Stat	
(0	r Herr	Fun	Armed Forces?  1 □ Never Married 2 ⊡ Married 1 □ Yes 2 ⊡ No		Was Decedent of Hispan f Yes, specify Cuban, Me		can, etc.)	Black, Whit	e, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Madical Examinar must be notified at	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		I□Yes 2ဩxNo Sp	pecify:		Specify: W	ITTE
15-	"natu	Completed	(Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	7 16t	o. Kind of Business	/Industry
212	withi	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		ne Maker			Own Home	
	al Hyg	Be C	17. Father's Name (First, Middle, Last)		18.	Mother's Name (	First, Middle, Mai	den Sumame)	
yla	ould b Ment Marksc	70	Ed Moore			lary Deel			
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event. The Madical Examinar must be notified at				og Address (Street and Noriole Circ				Zip Code)
	s 1 an f Heal item 2 other		20a. Method of Disposition 20b. Plac	e of Dispo	sition (Name of natory or other place)	Dai		. Location - City or	Town, State
e E	Page nent o ant: If arry or		1 LXBuria: 2 Cremation 3 Hemoval from State		ve Cemetery	12/23	3/2004 M	lt. Airy	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants: If item 27 is marked other than 'any injury or other traumatic event. It is M. ODGE.		21. Signature of Funeral Service Licenses		Name and Address of East Ridge				e 21771
			23a. Part1. Enter the direase, or complications that caused the death, shock, or heart trillure. It is only one-flause on each line.						Approximate
, II	Physician					acud			Interval Between Onset and Death
	/Medical Examiner		resulting in death)  a. Due to (or as a consequent	- 1					
н	Examiner	10	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent	nce of):					
	s insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	100 01).					
oʻ	te be executed ysician and le burial-transit	Еха	resulting in death) Last Due to (or as a consequent	nce of):					
8760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical	d						
x 68	ding p	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnance	v				23d Date of de	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at time of deal	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
P.O.	of the c by the tached	hysi	9 Unknown						
	Se Co	by	Part II. Other significant conditions contributing to death but not resulting to death but not resulti	ng in the u	ndertying cause given in	Part I.			o the cause of death?
Records,	w require s been si should I	Completed	Pulmonane Embol	(SW)			24a. Was an	24b. Were at	itopsy findings available
Re	sician: The law certificate has t irector, page 2 s	omp	, viring and	7711			autopsy performed	? death?	completion of cause of
Vital	cian: ertifica ector, p	BeC	25. Was case referred to medical examiner?			Place of Death (			
of \	Physician: this certifican al director,	은		VOutpatier			e 5 Residence	e 6 Other (Spe	cify)
O	Attending I r death. ector: After by the funer	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Injury	f 28c. Injury at Work?  M 1 ☐ Yes		d. Describe 1104 1	njury cocurred	Management of the second of th
Division	Attsr er dea ector by the	iffica	3 Suicide 6 Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, str	eet, factory, office	28	f. Location (Stree City or Town, S		ural Route Number,
Ö	Hospital or 24 hours afte Funeral Dir tely filled in	Cert							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:	29a. Certifier  (Check only one)  2   Medical Examiner: On the basis of examination and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of partitles	)	29c. License nur	mber 701	29d.	Date signed   Mont	h, Day, Year)
			· /////	/	1)	11/00		12/1	1/2004
(	3		30. Name-and address of person who completed cause of death (Item 2	3a) (Type,	Print) Oak MI	owe,	Hager	35toca,	MI) 2/742
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 2	Ar s	book		/	,	

04-8**1**54 B.K.S

CAROL	YN C. 1	DIX	_ State		State o	f Marylan	d / Depa	artment <i>tificate</i>	of H	lealth Death	and M	lental Hy		004	42173
			1. Decedent's Name	e (First, Middle, La	nst)		001	inoatt	0, 1	Journ		2. Date of De	Reg. No.		3. Time of Death
	Physici		Carol	yn Ruth	Dixon							DEC.	18, Day	)04 Year	0733 P M
	/Medio Examin		4a. Facility Name (/	If not institution, given	ve street and nu	mber)		4b. City,					4c. Co	unty of Death	
				ZLLIS DRI	VE					BURNI				VE ARUN	
	Funeral		5. Social Security N 218-36-4		Sex 1 □ M 2 DXF	7. Age (In yrs 64	last birthday) Yrs.	If Under Months	1 Year Days	Hours Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	Cou	place (State or Foreign Intry)
	Director		Usual Residence of			04						Mar.	26 <b>,</b> 194	U	VA
	nyland how		10a. State	10b. County	. 7 7	10c. Cît	y, Town or Lo								10d. Inside City Limits
:	86-1-9	cto	MD	Anne Ar	under			Glen :		ne					1 ☐ Yes 2 🙀 No
:	with the	Funeral Director	10e. Street and Nu					10f. Zip					10g. Citizer	of What Cou	intry?
	ne 23	era	17 Phy 13	lis Drive	12. Was Dec	edent Ever in U.	.S. 13. V	Was Deced		061 Ispanic O	rigin? (Sp	ecify Yes or No Rican, etc.)	o- 14.	USA Race - Ameri	ican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iteme 23e or 28e-f show importent: If item 27 is marked other then "naturel", or iteme 23e or 28e-f show any injury or other traumatic event. Its Madical Exactifier is used by inclined at ODGe.			ied 2 🔀 Marned 4 □ Divorced	Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2⊠No ve		fYes, spec		an, Mexica Specify		Rican, etc.)		Black, White, ecify:	
5-0	72 ho	eted	(Spec	15. Decedent's E			16a. Deced	kind of wor	rk doné d	during mo	st of work	ing	16b. Kind	of Business/Ir	ndustry
2	hen .	Completed by	Elementary/Seco	ondary (0-12)	College (		life. l	DO NOT us	e retired	1)		-	нудс	Contr	acting Co.
7	filed v Hygie ther t		17. Father's Name	·	t)		Adııı	inist	rati		-	e (First, Middle	1		accing w.
an	ld be entai ked o	To Be	Frankli	in C. Cla	rk						Ε	ora Bra	anham		
ary	shou and M e mar	-	19a. Informant's N				19b. Mailir	ng Address	(Street	and Numl	per or Rur	al Route Numb	er, City or To	own, State, Zi	p Code)
Σ	and 2 Balth a n 27 I			Roeder/Da	ughter	1				7, Pa		nea, MD			
Baltimore, Maryland 21215-0036	Pages 1 nent of Hi ant: If iter ury or oth			position  Cremation 3 [ 5 Other (Spec		a	Place of Dispo semetery, cren etro Ci	natory or o	ther plac	сө)	Dec.	21, 2004		ion - City or T imore,	
Balt	permit. Departr Importi		21. Signature of	uneral Service Lice	ansee		Ba 49	Name and Prance 5 Gov	d Addres	ss of Faci Sons itch	s, P. ie Hs	A. Seve	erna P	ark Fu	neral Home D 21146
1			23a. Prt1. Enter t shock, or hea	the disease, or cor art failure. List only	mplications that	caused the deat	h. Do not e <i>n</i> t	er the mod	e of dyin	ng, such a	s cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	on	_a(	SUISHO	T WOU	nd to	1 re	CK					Onset and Death
	/Medical Examiner		resulting in death)	- (	Due to	(or as a conseq	uence of):								
		ا و ا	Sequentially list co	onditions, mmediate	b. Due to	(or as a consaq	uence of):							_	
	uted d ansit	Examiner	Sequentially list co if any, leading to in Cause (Disease or that initiated events	r injury	C										
,0	icate be executed physician and s the burial-transit	i Exa	resulting in death)	Last	Due to	(or as a conseq	uence of):								
8760,	cate by	dicai		•	d						-				2004 Landston (1987)
O. Box 6	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2	months?	1 Live	itcome of pregna birth 2 □ Feta nant at time of d nown	ildeath 3□	Ectopic pr Other (sp		. —			23d	. Date of deliv Mo <i>n</i> th	rery Day Year
۵.	es that tigned by	by Ph	Part II. Other signi	ficant conditions	contributing to	leath but not res	ulting in the u	nderlying c	ause giv	en in Part	1.	23e. Did	tobacco use	contribute to	the cause of death?
rds	v requires been sign should be											1 🗆	Yes 2	lo 3□Pro	bably 4 🗀 Unknown
Division of Vital Records, P.O	The law requate has been page 2 should	Completed										24a. Was auto perf 152 Yes		4b. Were autoprior to condeath?	opsy findings available ompletion of cause of
/ita		Be (	25. Was case reference examiner?	rred to medical	Hospitals				I Oth	2-2070	1000	h (Check only			
of	Physic this crat dir	2	1 Yes 2 2 27. Manner of Dea		Hospital: 1  28a. Date		ER/Outpatier	A.	and the best of	4 🗆 🗅	lursing Ho	me 5 Res 28d. Describe			(fy) AT SCENE
L O	ting After fune	tion	1 Natural	5 Pending investigation	(Mor	nth, Pay Year)	n 32	PM	Wor	k?` Yes 2.Σ	No	-	TWAS		
N N	l or Attending after death. Director: After in by the fune	Certification;	3 Suicide 4 Homicide	6 Could not determine	be 28e. Plac	e of Injury - At he	ome, farm, str	eet, factory	, office	-					al Route Number,
از	늘 하는 근	Cert	4X Homicide		Build	ling, etc. (Specit	esideno	e				Glen B	WILL E	Mo	MIVE
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only	1 Cartifying F	aminar: On the										
	To the comp	Σ	29b. Signature and	d title of sertifier	Λ	11		290		e number . C . M				igned (Month,	
			•	1	W1. 2	1			J	5	_		DEC	. 19, 2	2004
_			30. Name and add	anti	Pur, Mil	11	1 PENN		EET,	BALT	TIMOR	E, MARY	ZLAND Z	21201	
	Sta Regist	ate rar	31. Date filed (Mo	DEC 2 0	2004	egistrar's Signa	St. A	mente	,						

			For State	State of Maryland / I	Department of Hea  Certificate of De	Ith and Mental Hy	giene 2004 42174
	•	V 1	Registrar  1. Decedent's Name (First, Middle, La	st)	Certificate of De	2. Date of D	eath 3. Time of Death
	Physici		Enrique S. Escob	•		Month	er 16, 2004 2:10 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, giv		4b. City, Town, or Loca		4c. County of Death
	Exami	ie.	Montgomery Villa	ge Health Care Ce	nter Gaithersb	urg	Montgomery
	Funeral Director		5. Social Security Number 6. S 216-76-1516		thday) If Under 1 Year If U		
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	darylist sho	ŏ		oru Silvor	Spring		1 ☑ Yes 2 ☐ No
	ith the Marylan or 28a-1 show	rect	MD Montgom  10e. Street and Number	ery Sirver	10f. Zip Code		10g. Citizen of What Country?
	3a or	I D	1400 Fenwick Lane	2	20910		Chile
	death	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispar	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Items 23a or 28a-f show important: If item 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic event, Itle Madicul Examination used the notified at once.	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Chilean	Specify: Hispanic
5-(	72 h "natu	Completed	15. Decedent's E (Specify only highest gra	ducation 16a ade completed)	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	16b. Kind of Business/Industry
121	within no.	Ig II	Elementary/Secondary (0-12)	College (1-4or 5+)	Waiter		Food Industry
5	Hygie ther ther	e Co	12 17. Father's Name (First, Middle, Last	)		Mother's Name (First, Middle	·
anı	d be	m	Enrique Escobar H			Ester Iturria	
Maryland	shoul nd Me mark	ို	19a. Informant's Name/Relationship (	0.00			per, City or Town, State, Zip Code)
Ma	nd 2 inth ar		Enrique Escobar,	Son 9	007 Centerway	Road, Gaither	sburg, Maryland 20879
Baltimore,	f Head the fittern to the	100	20a. Method of Disposition	20b. Place o	f Disposition (Name of ry, crematory or other place)	Date	20c. Location - City or Town, State
E	Page mit o		1 ☐ Burial 2 XCremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special			y 12/22/2004	Brentwood, Maryland
alti	partm partm sorta / inju		21. Signature of Funeral Service Lice	nsee	22. Name and Address of	Facility Simple	Tribute
m	Depar Depar Impor any ir		Nouttur 1.	andilin			ville, Maryland 20852
	Physician /Medical Examiner		23a. Par1. Enter the disea e, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused he death. Do one cause on each line.  Metastatic Pan  Due to (or as a consequence	creatic Cancer		arrest, Approximate Interval Between Onset and Death
,092	eath certificate be executed attending physician and for use as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  Due to (or as a consequence)			
876	cate b	dical		d			
.O. Box 68	o o	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	DOMIN	23d. Date of delivery Month Day Year
Δ.	requires that the		Part II. Other significant conditions of	contributing to death but not resulting	n the underlying cause given in	_	tobacco use contribute to the cause of death?  Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Records,	e law has b	Completed	11				prior to completion of cause of death?
Vital		a	25. Was case referred to medical		26.	l □ Yes	
Ξ	S D	OB	examiner? 1 ☐ Yes 2 🏹 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Other: 4	X Nursing Home 5 ☐ Res	idence 6 □Other (Specify)
ion of	ding After fune	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Time of Injury at Work?  M 1 Yes	28d. Describe	how injury occurred
Division	tal or Atters after de al Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined		arm, street, factory, office		(Street and Number or Rural Route Number, wn, State)
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1  Certifying Pl (Check only one) 2  Medical Example  Medic	nysician: To the best of my knowledg miner: On the basis of examination ar and manner stated.	nd/or investigation, in my opinio	n, death occurred at the time	, date and place, and due to the cause(s)
	To the To the complete	Σ	29b. Signature and title of certifier		29c. License nur	mber	29d. Date signed (Month, Day, Year)
	10		Viny G	(M)	D41162		December 16, 2004
	C		30. Name and add as of person who			Managa 1 1 000	7.
			Dr. Vinu Ganti, 1		e, Germantown,	maryland 208	/4
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  DEC 20 20	32. Registrar's Signature	9 Sports		

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Ma	arylan		artment o			and Mental	Hygie Reg.	ZUUL	42	175	
			Decedent's Name (First, Middle, La	ast)						2. Date	of Death		3. Time	of Death	
	Physici: /Medic		FAY BAUMGARTEN	N ELVOVE						DECEM		Day Ye <i>a</i>		A M	
	Examin	er	4a. Facility Name (If not institution, gir				4b. City, To		ocation o	f Death		4c. County of De			
		3	5. Social Security Number 6.		e (In vrs. i	last birthday)	FREDER		If Under 2	24 Hrs.   8. Date		FREDERIC	K Birthplace (State	or Foreign	
	Funeral Director			1□M 2 <b>X</b> )F		77 Yrs.			Hours		h, Day, Ye	ar)	SHINGTO	_	
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	nation						10d. Inside (		
	Maryla f sho	jo	MARYLAND FREDERICK FREDERICK											s 2 🗆 No	
	r 28e-	irect	10e. Street and Number	JA	FKE	DEKICK	10f. Zip Co	ode			10g.	Citizen of What	Country?		
	th wit	ai D	8406 RIVER MEADOW	V DRIVE				2170	)4			U.S.A.			
	er dea	nuel	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13.	Was Deceden If Yes, specify	t of Hisp Cuban,	anic Orig Mexican	jin? (Specify Yes , Puerto Rican, etc	or No-	14. Race - Ar Black, Wi	nerican Indian, nite, etc.		
38	urs aft	by F	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:			1 ☐ Yes 2 ☒ No Specify:						Specify:	WHITE		
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f show thi, Ite Medical Evar, it ar Irnel te rudified at	eted	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usual C	ccupatione dur	on	of working	16b	. Kind of Busines	ss/Industry		
2	ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use r	etired)	mg most	o, noning					
7 0	filed v Hygie Ifher t	CO	12 17. Father's Name (First, Middle, Las	t)		HOMEM	IAKER	18	8. Mothe	r's Name (First, M		N HOME			
a	lid be lental rked c	o B	SAMUEL	BAUMG	ARTE	N			1ARIE			FABER			
Maryland 21215-0036	and N		19a. Informant's Name/Relationship				ng Address (S			r or Rural Route N	umber, Ci		, Zip Code)		
≥ ຜົ	1 and 1ealth 9m 27		SOLOMON ELVOVE/HU 20a. Method of Disposition	JSBAND	20h P	_	RIVER		OOM I	OR., FRED	-				
nor	ages int of the		1 X Burial 2 ☐ Cremation 3 [		C	emetery, crei	matory or othe	r place)	27.0			. Location - City			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural; or Items 23a or 28e-f show any injury or other traumatic event, the Medical Exercities from the rediffice at once.		*4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		PARI					2/17/200 RG MEMOR				ND	
Ö —	P P P P P P P P P P P P P P P P P P P		Sonald (	Stattler		2/11	/U ROC.	KVII	LE P	IKE, ROC	KVILI	LE, MD 2	0852		
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line of the cause											tween	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. CARDIAC ARRHYTHONIC  Due to (or as a consequence of):												
	Examiner		CODONADY ADTEDY DICEAGE												
	= q	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	aanda of):							1				
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	uence of):											
8760	death certificate be executed e attending physicien and id for use as the burial-transit	cai E	(												
9	rtificate ng phys as the	O	IF FEMALE:												
Box	eath certific attending p for use as 1	lan/	23b. Was decedent pregnant	Was decedent pregnant  n the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of d	delivery Day Year		
O,	that the de ed by the a detached f	Physician/Me	1 Yes 2 No 9 Unknown 5 Other (specify) Unknown							_		,			
ري ص	The law requires that the te has been signed by the rage 2 should be detached.	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e.	23e. Did tobacco use contribute to the cause of death?				
ğ	w require been sig should b	ted t	ALZHEIMERS	-						<u></u>	1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown				
ĕ Ç	has be	Completed									Was an autopsy	prior to	autopsy findings completion of	available cause of	
Vital Records,			OF War and the modical							1 🗆 Y			as 2 No		
	S 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1   Inpatie	nt 2 🗆	ER/Outpatier	nt 3 DOA	Other:		of Death (Check of Sing Home 5X)		6 Other (Sc	necify)		
0	ding Phy th. After thi funeral of	T :uc	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y	28b. Time of		Injury at Work?				njury occurred			
Division of	vttendir death. ctor: Al y the fu	catio	2 Accident investigation	20			M		s 2 🗆 N		(2)				
	l or Attendent efter deat Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Colld not be determined  5 ☐ Colld not be determined  6 ☐ Colld not be determined  6 ☐ Colld not be determined  7 ☐ Homicide  8 ☐ Colld not be determined  9 ☐ Colld not be determined  1 ☐ Colld not be determined  1 ☐ Colld not be determined  1 ☐ Colld not be determined  1 ☐ Colld not be determined  1 ☐ Colld not be determined  1 ☐ Colld not be determined  1 ☐ Colld not be determined  1 ☐ Colld not be determined  2 ☐ Colld no								Hurai Houte Nur	nber,			
	To the Hospital or Al within 24 hours effer of To the Funarel Direc completely filled in by		29a. Certifier 1 X Certifying 7	hysician: To the best o	of my know	wledge, deatl	n occurred at t	he time,	date and	place, and due to	the cause	(s) and manner	as stated.		
	To the H within 24 To the F complete	Medicai	one)	and manner sta	ted.	and/or in				n occurred at the t			<u> </u>	s)	
}	wit or T		29b. Signature and titll of certifier	Li			201	Cense n	75	MX		Date signed (Moi			
	15		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type.	Print)	,- (		, ,/	DEC	CEMBER 1	5, 2004		
			JOEL L. GOOZH, M.	D., 6410 R	OCKL	EDGE D		SUIT	E 40	1, BETHE	SDA,	MARYLAN	D 20817		
	Sta		31. Date filed (Month, Day, Yeak)	32. Registra		ture 🗼	doa								
	Registr	al	DEC 20	2004			1								

04-8008 B.K.S RYAN H. EASLEY

ΙН.	EASLE	Y	State of Maryland / Department of Health and Mental F  1- For State of Maryland / Department of Health and Mental F  Certificate of Death	Hygiene 0 0 4	42176			
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Month DEC.		3. Time of Death 0712 A M			
	/Medic Examin		At the White the second of the	4c. County of Dea PRINCE G				
	Funeral Director		Months Days Hours Min. (Month,	te of Birth onth, Day, Year)  9. Birthplace (State or Foreign Country)  1. 31, 1978 Maryland				
	death with the Maryland ms 23a or 28a-f show	tor	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1   ↑ Yes 2   No			
	th with the Mi 23a or 28a-1 : ust be notifie	Funeral Director	10e. Street and Number 4825 Berwyn House Rd. 20740	10g. Citizen of What Co	ountry?			
		inera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA TNo- 14. Race - Ame Black, Whit				
9036	urs at',	by	3 ☑ Widowed 4 □ Divorced   If Yes, Give Year or Dates:	Specify:	White			
1215-(	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", raumatic event, It's M. Jic. I Exa	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16b. Kind of Business.	/Industry			
1d 21	e filed w I Hygiei other ti vent, Ita	Be Col						
ylar	nould be d Menta narked natic ev	10 E	Elmer Houston Easley, Jr. Kristine Seaq					
Mai	alth and 2 st		19a. Informant's Name/Relationship (Type, Print)  Kristine Easley-Agee- Mother  19b. Mailing Address (Street and Number or Rural Route Number of Rural Rou		zip Code)			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturary intry opother traumatic event, it is M. Jical Once.		20a. Method of Disposition  1	20c. Location - City or 04 Brentwood,				
Balti			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rin 11800 New Hampshire Ave.					
	Pnysician /Medical Examiner		23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a construence of):	ry arrest,	Approximate Interval Between Onset and Death			
,8760,	rate be executed hysician and the burial-transit	Completed by Physician/Medical Examiner	Ilcal Examiner	Ilcal Examiner	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Understying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d		
P.O. Box 6	the death certific y the attending p iched for use as t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date ol del Month	ivery Day Year			
	w requires that the death been signed by the atte should be detached for	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. D	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown				
Il Reco	The lay ate has page 2	Complet	24a. V a p 1	24a. Was an autopsy performed?  1 Yes 2 No 1 24b. Were autopsy findings averaged prior to completion of caudeath?  1 Yes 2 No				
Vita	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?		city) AT SCENE			
Division of Vital Records,	ling I	Certification; T	27. Manner of Death  1  Natural 5  Pending investigation  2  Accident 3  Suicide 6  Could not be determined    28a. Date of Injury (Month, Day Year)    1  Natural 7	ome 5 Residence of Other (Specify) AT SCENE  28d Describe how injury occurred  Pa56enger INVOLVED IN A  NOTO VELLE  281. Location (Street and Number of Rural Route Number, City or Town, State) WIRRE.				
-	To the Hospital or Atteno within 24 hours after death To the Funeral Director: completely filled in by the I	Medical Ce		the cause(s) and manner as	stated.			
)	(1)	Me	29b. Signature and title of certifier  O.C.M.E	DEC. 14, 2				
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CAROL HALLAW MA 111 PENN STREET, BALTIMORE, MARY					
	Sta Registr		31. Date liled (Month, Day, Year)  32. Registrar's Signature	- LAND - 212VI				

#### Plea e.

ase	Type or I	Print in	Black	Indelible In	k. Ensure	All	Copies	Are	Legibl
	State o	f Manula	nd / Do	nartment of	Hoalth an	d M	antal Hw	rione	

L		14	For State Registrar	State of Mi	-	epartment of H			erve 004	42177
			Decedent's Name (First, Mid	idle, Last)				2. Date of Deat	h	3. Time of Death
	Physici /Medic		Melanie	Evelyn		Easley		DEC.	$13^{ay}, 2004^{ear}$	0712 A M
,	Examir		4a. Facility Name (If not institut ROUTE # 193 A	ion, give street and number) TRHODDE ISLA	AND AVENUE	4b. City, Town, or GREENB	Location of Death ELT		PRINCE (	ath GEORGES
	Funeral Director		5. Social Security Number 212-94-1659	6. Sex 7. Ag	ge (In yrs. last birthd 25	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 7.		nthplace (State or Foreign Country) Shington, D.
	yland		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town or	Location				10d. Inside City Limits
	e Mar	ctor	Maryland Prin	ce Georges	College	Park				1 ☐ Yes 2 ☒ No
	vith the	Director	10e. Street and Number	-		10f. Zip Code			0g. Citizen of What C	Country?
	ns 23s	Funeral	4825 Berwyn Ho	12. Was Decedent	Ever in U.S. 1	20740 3. Was Decedent of Hill Yes, specify Cuba	spanic Origin? (Spe		U.S.A. 14. Race - Am	terican Indian,
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked other than "natural", or Itams 23a or 28a-f show itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant. The Marical Exp. direct mat Le notified at	by Fun	1 ☐ Never Married 2 ☐ M 3 🏝 Widowed 4 ☐ Divorce	Armed Forces?  1 ☐ Yes 2 X	No	If Yes, specify Cuba 1 ☐ Yes 21亿 No		Rican, etc.)	Black, Wh	ite, etc. sian
2-0	72 ho "natur	Completed by	15. Deced (Specify only high	lent's Education hest grade completed)	16a. De	ocedent's Usual Occupa ive kind of work done of e. DO NOT use retired	ition Juring most of work	ing	16b. Kind of Busines	s/Industry
12	within ene. than	dmo	Elementary/Secondary (0-12		5+) Ope	erations An	alyst		General	Electric
<u>d</u> 2	2 should be filed withir and Mental Hygiene. is markad other than aumatic avant, ITK M.	a	17. Father's Name (First, Middle	le, Last)			18. Mother's Name	(First, Middle, N	Aaiden Sumame)	
ylar	ould be d Mental narkad o	To B	Harry Lee				Karen Er	9		
Maryland	12 sho hand 7 is m traum		19a. Informant's Name/Relatio			ailing Address (Street a			•	
	1 and 2 Health tam 27		Karen Putt /	Mother		sposition (Name of crematory or other place			20c. Location - City o	
nor	Pages ent of resident of or		1 🖾 Burial 2 🗀 Crematio  1 4 □ Donation 5 □ Other	n 3 □Removal from State (Specify)	'	crematory or other place Heaven Cem	l l	/2004	Silver Spr	ing, Maryla
Baltimore,	permit. Pages: Department of H Important: If its any injury or ot		21. Signature of Funeral Servi	ce Licensee		22. Name and Address	s of Facility Hir	es-Rina	ldi Funera	al Home, Inc ng, MD 20904
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cause ist only one cause on each li	d the death. Do not line.	enter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Nue to (or as	ultiple F s a consquence of):	nuvies				Onset and Death
	uted 1 insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	b. — Due to (or as	s a consequence of):					
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Exa	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
Box 68	uth certifica Itending ph or use as th	450	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy			23d. Date of de	elivery Day Year
0.	he dear the a	ysic	1 ☐ Yes 2 ☐ No 9 █ Unknown	4□Pregnant a 9□ Unknown	it time of death	5 ☐ Other (specify)				
Ω.	uires that the death cer n signed by the attendin ld be detached for use	d by Physician/M	Part II. Other significant cond	litions contributing to death b	but not resulting in th	e underlying cause give	en in Part I.	23e. Did tob	100	to the cause of death?  Probably 4 Unknown
Records,	The law requiresate has been sinpage 2 should b	Completed				-		24a. Was an autops perform	n 24b. Were a prior to death?	autopsy findings available completion of cause of
Vital	10	Be C	25. Was case referred to med examiner?				26. Place of Deatl			
of V	Physician: this certific ral director,	2	1 X Yes 2 ☐ No	Hospital: 1 Inpati		atient 3 DOA Othe	4 🗀 Nursing Ho			ecity) AT SCENE
ou	fter	tlon:	27. Manner of Death  1 Natural 5 Pen	28a. Date of Injured (Mont Date of Injured (Mont Date of Injured Injur	ury 28b. Tim lnju	ry Work	(? (as 25 <b>7</b> (Na )	- /	w injury occurred	ellier.
Division	l or Attanding after death. Diractor: After	Certification:	3 ☐ Suicide 6 ☐ Cou	uld not be 28e. Place of In		, street, factory, office		28f Location (St	reet and Number or F	Bural Boute Number
	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu	edical C	29a. Certifier 1 Certification Check only 2 Medic	fying Physician: To the best cal Examiner: On the basis of and manner st	t of my knowledge, d	leath occurred at the time or investigation, in my of	ne, date and place, pinion, death occurr	and due to the ca	ause s) and manner a ate and place, and du	as stated. ue to the cause(s)
)		Me	29b. Signature and title of cert	ifier M. A	,	29c. License O.C	·M.E	29	DEC. 14,	nth, Day, Year) 2004
	10		30. Name and address of pers	con who completed cause of a Tiffy Min).	death (Item 23a) (Ty	pe, Print) NN STREET,	BALTIMOR	E,MARYLA	AND 21201	XX 117 552.0
	St Regist	ate rar	31. Date filed (Month, Day, Ye DEC 2		trar's Signature	Sporks	/			

		riease i	• •	indendie ink. Ensure A	-					
		For State		partment of Health and Mertificate of Death		/ 1111/2	42179			
		Registrar  1. Decedent's Name (First, Middle, Last)		ertificate of Death	2. Date of Death	g. No.	3. Time of Death			
Physic	ian	Robert Eugene Fre				25, 2ď84	12:10 A.M			
/Med	ical	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death				
Exami	ner	40 Crystal Fall		Smithsburg		Washing	rt on			
Funeral		5. Social Security Number 6. Sex		ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		place (State or Foreign intry)			
Director		219/20/1109	{M 2□F 80 Yrs	Months Days Hours Min.	Februar		aryland			
P		Usual Residence of Decedent								
urylar	_	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
Be-1 s	cto	Maryland Washing	ton	Smithsburg						
vith th	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou				
be filed within 72 hours atter death with the Maryland la Hygiene. Id other than "natural", or ttems 23a or 28e-1 show event, the Modical Examinat rival be souldied at	Funeral	40 Crystal Fal		21783	pocify Voc or No	U.S.A.				
them them	nue	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces?  12 Yes 2 No 1943	<ol> <li>Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	Black, White				
irs aff	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1946	1 ☐ Yes 🎾 No Specify:		Specify: W!	nite			
within 72 hours after one. It was a series of the man and training the Madical Examination.		15. Decedent's Edu	cation 16a. De	ecedent's Usual Occupation	1	16b. Kind of Business/Ir	ndustry			
New Company	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) (G lift College (1-4or 5+)	ive kind of work done during most of wor e. DO NOT use retired)	king					
d with	Completed	12		Supervisor		State Roa	ads			
e filed al Hygi other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, M	Middle, Maiden Surname)				
	To	Harry L. Frey			C. Smi					
and and ts mu		19a. Informant's Name/Relationship (Ty		ailing Address (Street and Number or Ru						
i e, ival yic s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Geraldine E. Fi			r. Smithsburg, MD 2178 Date 20c. Location - City or Town, State					
0 0 = =		20a. Method of Disposition  1 XBurial 2 Cremation 3 P	temoval from State cemetery,	sposition (Name of crematory or other place)	ember					
Pa men ent:		`4 □Donation 5 □Other (Specify)		wn Cemetery 29						
Dall permit. Depart Import any inj		21. Signature of Funeral Service Licens	, 101717			is Funera				
	1	Je Mich Lace	Davis	12525 Bradbury	AveSm	ithsburg,	MD 21783 Approximate			
			ne cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	N. C.	Interval Between			
Physician /Medical	_	Immediate Cause (Final disease or condition resulting in death)	· CHRONIC C	obstructive pulm	monsey	Diserse	5 YTARS			
Examiner			Due to (or as a consequence of):		1					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							
uted ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
executed executed in and rial-transit	Exa	resulting in death) Last	Due to (or as a consequence of):							
5 8 6	cai		J							
tifica ig ph as t	Physician/Medi	IS SEMALS.								
th cer tendir	ar/	230. was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of deliver Month	very Day Year			
e death he atter	sici	in the past 12 months?  1  Yes 2 No	4☐Pregnant at time of death 9☐ Unknown		World	Day Four				
vequires that the deben signed by the should be detached	Phy	9 Unknown Part II. Other significant conditions co	atributing to dooth but not regulting in th	no underhina cauce awen in Part I	23e Did tob	agen use contribute to	the cause of death?			
res the signed be d	þ		fensin	N⊇Ye	23e. Did tobacco use contribute to the cause of de					
w requires been sign should be	Completed	- O Para	1000							
- S O	id m				24a. Was ar autopsy perform	v / prior to d	topsy findings available ompletion of cause of			
ate Th					1 ☐ Yes 2	1 Yes	2 No			
Oi VICAL DE Physician: The Is rithis certificate harral director, page 2	o Be	25. Was case referred to medical examiner?	Hospital:	Others	th (Check only on					
Phy C	_ ⊢	27. Mann a f Death	1 ☐ Inpatient 2 ☐ ER/Outpa 28a. Date of Injury (Month, Day Year) 28b. Tim Inju	te of 28c. Injury at	28d. Describe ho	nce 6 Other (Spec	ny)			
Attending For death.  ector: After by the funer	ţ	1 - Actural 5 Pending 2 Accident investigation	(Month, Day Year) Inju	ry Work? M 1 ☐ Yes 2 ☐ No						
LIVISION  al or Attending after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm	, street, factory, office	28f. Location (Str City or Town	reet and Number or Ru	ral Route Number,			
a after in Direction	Certification:	4 Homicide	building, etc. (Specify)		City of TOWN	, Siale)				
Hospital Hospital Puneral I		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, of	leath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the ca	ause(s) and manner as	stated.			
he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Exami	and manner stated.	or investigation, in my opinion, death occu						
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the th	Σ	29b. Signature and title of certifier	40	29c. License number		9d. Date signed (Month				
		yuu		D43590	/	2-29-	04			
~		36. Name and address of person who c	Appleted cause of death (Item 23a) (Ty	pe, Print) Refore BUD SMI	TUCKION	410 211	B P			
	1	31. Date filed (Month, Day, Year)	32 Registrar's Signature	IGM BUIL JMI	1 " Dunce	NU CIT	·			
S	tate	17 N O 6 201		Coull D						

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			1 - For State Registrar	State of	Marylar		artment <i>rtificate</i>		alth and Meath		giene	4004	42	179
ı	Physici /Medic		1. Decedent's Name (First, Middle, La LILLIAN M.	FORAKI	ΞR				-	2. Date of De. Month DECEMI	Da			of Death
	Examir		4a. Facility Name (If not institution, given	e street and numb	oer)		4b. City, To	own, or Lo	ocation of Death		40	. County of Dea	th	
			137 Center Str 5. Social Security Number 6.5		. Age (In yrs.	last histoday	Cec If Under 1	ilto	n f Under 24 Hrs.	O. Data of Bird		Cecil	th 1 (2)	
	Funeral Director			1  M 2  F	72	Yrs.			Hours Min.	8. Date of Bird (Month, Da Aug 15	y, Year)	932 Ma	thplace (Stat ountry) rylan	
	arylanc show	_	10a. State 10b. County			ty, Town or Lo							10d. Inside	,
	he Ma 28a-f	Funeral Director	MD Cecil		Ce	ecilt								es 2 No
	with	Ö	137 Center St	coct			10f. Zip C					tizen of What Co	ountry?	
	Jeath Te 23	era	137 Cerroer Scr	12. Was Deced	ent Ever in U	.S. 13.		913 nt of Hispa	anic Origin? (Spe Mexican, Puerto	ecity Yes or No		<b>S • A •</b> 14. Race - Ame	erican Indian.	
980	permit. Pages 1 and 2 should be filed within 72 hours alter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or iteme 23a or 28a-f show any injury or other traumatic event, it e Medical Exciting it ust be usuffied at once.	by	1 ☐ Never Married 212 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forc 1 Tyes 2 If Yes, Give Year or Date	No.		If Yes, specif		Mexican, Puerto Specify:	Rican, etc.)		Black, White	te, etc. Vhite	
Maryland 21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usual	Occupation done during	n ing most of work	ina	16b. K	and of Business	/Industry	
121	within ane. then	mpi	Elementary/Secondary (0-12)	College (1-4	lor 5+)		<i>DO NOT</i> use Omemal				_	own Hor		
d 2	filed Hygie other ent,		10 17. Father's Name (First, Middle, Last	)		110	Jiiema	1	3. Mother's Name	(First, Middle,			iie	
/lan	wid be Mental rrked ritc ev	To Be	Howard Park						Ora C1	ark				
dan	2 sho and I Is me	. 2	19a. Informant's Name/Relationship (	Туре, Print)		19b. Mailir	ng Address (	Street and	Number or Rura	I Route Numbe	r, City o	or Town, State,	Zip Code)	
	s 1 and 2 of Health a item 27 ls other trai		Walter Foraker 20a. Method of Disposition	(hus		Place of Dispo				lton,		21913 ocation - City or		
nor	ages ant of it: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Special	Removal from St	ate C	emetery, crer alena	natory or oth	er place)				ena, N		
Baltimore,	mit. Partme partme portan / injur		21. Signature of Fune of Nervice Lipe		1				eral H					
ä	permi Depar Impor any ir	0	YXV		M005	10 11	l8 Wes	run st C	eral H ross S	ome of t. Gal	ena	ephen MD.	L. Sc 21635	chaeci 5
			234. Part1 Enter the disease, or come chock, or heart failure. List only	plications that cau one cause on eac	sed the deat								Approxim Interval B	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	1eta	5+0-	tic	00	ma	1			Onset an	d Death
	Examiner		1	Due to (or	as a conseq	uence of):								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Duato (or	as d conseq	ue. ເບອ ປີ).								
1	acuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	cate be executed physician and the burial-transit	cai Ex	resulting in death) cast	Due to (or	as a conseq	uence of):								
687	iticate g physis	73		_ d										
Вох	death certitic e attending p d tor use as l	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic pred					23d. Date of del	ivery	
		Physician/Me	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		nt at time of d		Other (spec					Month	Day	Year
P.0	that the deby the		Part II. Other significant conditions of	ontributing to deat	th but not res	ulting in the ur	nderlying cau	ise niven ir	n Part I	23e. Did to	bacco (	use contribute to	the cause of	f death?
Vital Records,	Se US	d by						3			es 2		obably 4	
CO	law requir as been si 2 should l	Completed								24a. Was		24b. Were au	topsy finding	s available
m		Com								autop: perfor		death?	completion of 2 \( \subseteq \text{No} \)	cause or
Vita	Physicien: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor	3. Place of Death	1	10)			
o	Phys this ral dii	- To	1 ☐ Yes 2 No  Manner of Death	28a. Date of I	Injury	ER/Outpatien 28b. Time of			4 Nursing Hor	ne Resid		6 □Other (Spec	cify)	
ion	Attending Phy r death. ector: After thi by the funeral o	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury	М	: Injury at Work? 1 Tyes	2 🗆 No					
Division	- 9	ertification:	3 Suicide 6 Could not b 4 Homicide determined	200. Flace 01	Injury - At ho , etc. <i>(Specif</i> )	ome, farm, stre	eet, factory, c	office	2	8f. Location (S City or Tow	treet an n, State	d Number or Ru )	iral Route Nu	mber,
	To the Hospitel or within 24 hours ette To the Funerel Dir completely tilled in	edical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the be niner: On the basi and manner	s of examina	wledge, death tion and/or inv	n occurred at vestigation, in	the time, d	date and place, a on, death occurre	and due to the co	ause(s) late and	and manner as I place, and due	stated. to the cause	(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and Me of certifier				29c. L	icense nu	ımber	2	29d. Dat	e signed (Month	n, Day, Year)	-
)			· / / /	n			DO	0517	86		Dec	ember	28,	2004
	6	1	30. Name and address of person who	/ /					<b>6</b> -3			)(D 01	C C C	
	Sta	te	Andrew S. Fe-r 31. Date filed (Month, Day, Year)	guson,	M • D • istrar's Sign●		speed	r Rd	• Chest	tertow	n,	MD. 21	620	
	Registr		31. Date filed (Month, Cay Year)	US Sleen	istrar's Sign	149								

State of Maryland / Department of Health and Mental Hygienen For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 23:20 PM 24 12 0 UIT a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Leonardtown
Hillinder 1 Year | If Under 24 Hrs. St. Mary's Hospital St. Mary's If Under 1 Months Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Vear) Hours 1 □ M 2 ■ F Director 01 None Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the rotified at once. 1 Yes 2 No Director Leonardtown Maryland St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 22872 Lawrence Avenue 20650 by Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wayne hene ပ 19a. Informant's Name/Relationship (Ty a rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheneka Banks/ Mother P.O. Box 2448, Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-30-2004 Leonardtown, MD \* 4 □ Donation 5 □ Other (Specify) Charles Memorial 21. Signatura Funeral Service Lice 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. M00052 22955 Hollywood Road, Leonardtown, MD Brinsfield, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 RONE ar disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** + were Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛂 No 9 Unknown 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 1 ☐ Yes 2 📈 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 X inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA Medicai Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation 1 Natural 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060397 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 200 Registrar DEC 0

State of Maryland / Department of Health and Mental Hygiene 1,2181 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:50P M Arnaldo Fumagalli December 12, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√ M 2□ F 231-45-9520 95 May 21, 1909 Italy Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show r Items 23a or 28a-f shov ther trust be notified at 14 Yes 2 No Maryland Prince Georges Director Laytonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5610 Griffith Rd. 20882 USA death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Ite any injury o other treumatic event, the Moderal Experience and any injury of the Fire inferiors. I □ Yes 2 No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. \$ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Genoveffa Ferrari ٩ Angelo Fumagalli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Claudio Fumagalli- Son 5610 Griffith Rd. Laytonsville, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 24 Cremation 3 Removal from State Ft. Lincoln Crematory 12/14/2004 Brentwood, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed that initiated events resulting in death) Last physician ar s the burial-tr Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy rector, page 2 performed' 2 No 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 💥 No 1 ☐ Inpatient 2 ☐ ER/Outpatient ၉ 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check or onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa D22780 December 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter M. Schissler, M.D. 7500 Greenway Center Dr. Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State ooch 20 2004 Registrar

			1 - Stete Registrar	ate of Ma	ryland / Depa <i>Cei</i>	rtmen tificate					giene Reg. No.	004	42182
П	Physicia	an	Decedent's Name (First, Middle, Last)  Elloanous Many Course					-		2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		Eleanor Mae Guy  4a. Facility Name (If not institution, give street	and number)		4b. City,	Town, or	Location of		December		004 ounty of Death	12:22A M
	Examin	eı	Solomon's Nursing Cente			Solo					Calv	ŕ	
	Funeral		5. Social Security Number 6. Sex 1 M		(In yrs. last birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Birt (Month, Day	h	9. Birth	place (State or Foreign ntry)
	Director		577~01-3234	-XX'	36 Yrs.					(Month, Day Feb. 6,	1918	Mary	land
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits
	e Mar ta-fst	ctor	Maryland St. Mary's		Clements								1 □ Yes 2√□No
	vith th	Dire	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Cou	ntry?
	eath v	erai	39011 Sonnie Way  11. Marital Status 12. V	/as Decedent E	ver in U.S. 13.V		624 tent of His	spanic Orig	gin? (Spe	cify Yes or No-	USA 14	Race - Ameri	can Indian
ထ	within 72 hours after death with the Maryland ene. Than "netural", or Items 23e or 28a-f show in Medical Examinat must be notified at	by Funeral Director	1 □ Never Married 2 □ Married 1	rmed Forces? ☐ Yes 21∏ No	, I	f Yes, spec	offy Cubar	n, Mexican	, Puerto	Rican, etc.)	j	Black, White,	etc.
003	ural', c		3 ∏Widowed 4 ☐ Divorced	Yes, Give ear or Dates:		I∐Yes 2	21A NO	Specify:			St	pecify: Whi	Lte
15-1	n 72 h •netu	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	16a. Deced	lent's Usua kind of wor DO NOT us	rk done d	lurina mosi	t of worki	ng	16b. Kind	of Business/In	dustry
212	withly jene. r than	ошь	Elementary/Secondary (0-12) C	ollege (1-4or 5+	)	Opera					Teleph	none Comp	oany
Maryland 21215-0036	al Hyg	Be C	17. Father's Name (First, Middle, Last)			•	A. Calabana	18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)	
yla	ould b Ment arkec	Tol	William Parran Farr							eanor Da			
Mar	d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (Type, F		213					I Route Numbe		own, State, Zip	Code)
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merital Hygiene.  Department of Health and Merital Hygiene.  Important: If item 27 is marked other than "netural; or Items 23e or 28a-f show amy injury or other traumatic event, The Medical Examinational be notified at once.		Mary Martha Griffin/Daug 20a. Method of Disposition	nter	20b. Place of Dispo	sition (Nan	ne of			and 206:		tion - City or To	own, State
Baltimore,	Pages sent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	al from State	St Aloysiu	-			ec. 2	8,2004	Leonaro	itown.Mar	ryland
alti	permit. Pag Department Important: I any injury c		21. Sign itu e of Funeral Service Licensee	1	A /	. Name an		s of Facilit	У				
	90 E 29		Michael Heven 7	arden	n					neral Hor 20650		0. Box 2	
н			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	is that caused to use on each line	he draft. Do not ente	er the mode	e of dying	g, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Priysician /Medical	× j	Immediate Cause (Final disease or condition resulting in death)	Due to for an a	consequence of):	~U ~O						-	2 weeks
P	Examiner			Due to to as a	consequence or).								
	p Æ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):								
_	and and I-trans	Examine	that initiated events c	Due to (or as a	consequence of):								
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical E	d	·	, ,								
9	tificate ng phy as the	fedic											
Вох	leath certific attending p	Physician/Me	in the past 12 months?	yes, outcome o □Live birth 2	Fetal death 3	Ectopic pro					230	d. Date of delive Month	ery Day Year
0		ysic	1 Ves 2 TNo	□Pregnant at ti □Unknown	me of death 5	Other (sp	ecify)						-2,
σ.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions contribu	ting to death but	not resulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	contribute to the	he cause of death?
rds	w requires that been signed to should be det	ed b	DIZHeiners X	Loution						1 □ Y	es 2 🗆 i	No 3 ☐ Prot	pably 4 Dunknown
of Vital Record	S S S	Completed								24a. Was autop	sy	24b. Were auto	ppsy findings available mpletion of cause of
E E	Th ate pag	Соп								perfor 1 ☐ Yes	med? 2 No	death? 1 🗌 Yes	2 No
Vita	Physicien: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	al:		-	Othe			(Check only of			
oţ	Phys or this oral di	1; To		a. Date of Injury	28b. Time of		8c. Injury	at		ne 5 🗆 Resid 28d. Describe h			ý)
ion	Attending In death.	atio	1 ☐ Aatural 5 ☐ Pending investigation	(Month, Day	rear) Injury	М	Work	?? /es 2 □ l	No				
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28	e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory	, office		1	28f. Location (S City or Tow	itreet and N n, State)	lumber or Aura	al Route Number,
	Hospitel of 24 hours af Funerel D		29a. Certifier 1 Certifying Physicien	a. To the best of	my knowledge, death		at the tim	o data an	d place of	and due to the	201120/2/ 22	d mannar an a	totad
	e Hospitel 24 hours a e Funerel I letely filled	edical	(Check only 2 Medical Exeminer:	On the basis of a and manner state	examination and/or inv	estigation,	in my op	inion, dea	th occurr	ed at the time, o	date and pla	ace, and due to	the cause(s)
	To the I within 24 To the F complete	Me	29b. Signature and title of certifier	^		29c	. License	number			29d. Date s	igned (Month,	Day, Year)
			) /w /or.	1,00			076	314	n	ar	12	27/01	1
4	100		30. Name and address of person who comple				<i>c</i> ·	. 01	0 5	~	Jan c. 3	d at - 35	20678
	Sta	to	Paul V. Pomilla, M.I  31. Date filed (Month, Day, Year)	32. Registrar	Hospital l	xoad,	Sul	te 31	.U, P	rince F	reaer	ICK, M	ararid
	Registr		DFC 2 7 200		n. 18 1.	South	9						

			1 = For State Registrar	State of Marylar		artment of F		ntal Hygier	200L	42183
	0.0		Decedent's Name (First, Middle, L.	ast)				. Date of Death		3. Time of Death
	Physicia /Medid Examin	al	Ruth Imogene Gr 4a. Facility Name (If not institution, go			4b. City, Town, or	r Location of Death	December	Day Year  15, 2004  4c. County of Dear	
	Funeral		Holy Cross Hos 5. Social Security Number 6.	oital Sex 7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •		Spring   If Under 24 Hrs.   8   Hours   Min.	Date of Birth	Montgon 9. Bird	nery hplace (State or Foreign buntry)
	Director		286-14-0361 Usual Residence of Decedent	83	Yrs.		1 1 1 .			nio
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Li	ocation				10d. Inside City Limits
	Mary s-f sh	tor	Maryland Mon	tgomery Wh	eaton					1 ☐ Yes 2 🙀 No
	or 28,	Olrec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath w	rall	11914 Lafayette			2090:			JSA	
	ter de Items	<b>Funeral Director</b>	Marital Status     Never Married 2  Married	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Speci an, Mexican, Puerto Ri	ty Yes or No- can, etc.)	14. Race - Ame Black, Whit	
920	urs af	by	3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 21€ No	Specify:		Specify: Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g		(Give	edent's Usual Occup	during most of working	16b.	Kind of Business	Industry
2	vithin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	3)			
	filed v Hygie Wher t		12 17. Father's Name (First, Middle, Las	st)	Hon	nemaker	18. Mother's Name (	First, Middle, Maid	Own Home en Sumame)	
an	lid be lental ked o	To Be	George Forbes				Willa Be	etts		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ing Address (Street	and Number or Rural I	Route Number, Cit	y or Town, State, 2	Zip Code)
	and 3		Gary M. Greenfie		14308	Pidcadi:	ly Road, S			
lore	P S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 ★Burial 2 Cremation 3	☐Removal from State	cemetery, cre	osition (Name of matory or other place	_ Decemi	oer 28	Location - City or	
Baltimore,	it. Pa intmen intent: njury		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lio		Ceme	on Nation	nal 200	04 Ari	ington,	Virginia
Ba	Department of the sany is		> Solu E!	Sarfin	Ē	rancis J 00 Unive	ss of Facility Collins Frsity Blvd,	Funeral H , W, Silv	Iome Inc er Sprin	g, MD 20901
			23a. Part1. Enjer the disease, or co shock, or heart failule. List on	mplications that caused the dea y one cause on each line.	th. Do not en	ter the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Caus disease or condition resulting in death)	a Sepsis						Criser and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Pneumonia  Due to (or as a consec	juence of):					
	cuted td ransit	Examiner	that initiated events	C						
,092	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
6876	icate be executed physician and s the burial-transit	dical		d						
Box 6	death certific e attending pl id for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. Date of de	livery
.O. W	that the death certificate ed by the attending phys detached for use as the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
<u>P</u>	res that th igned by be detacl	/ Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the t	underlying cause giv	en in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
rds	law requires that the as been signed by th 2 should be detache	ed by					<del>.</del>	1 ☐ Yes	2 □ No 3 □ Pr	robably 4 Minknown
Record	e law re has bee	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
a H	Th ate pag						<u>.</u>	performed 1 ☐ Yes 2x☐		2 No
Vital		o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No	Hospital: 1 🔀 Inpatient 2	EB/Outpatio	oth 317 DOA Oth	26. Place of Death (		6 DOthor (Coa	mife.)
of	g Physer this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of			d. Describe how in		Cny)
Sior	Attending ir death. ector: After by the fune	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	ion	,ary		Yes 2 □ No			
Division	or Attendate after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, st	treet, factory, office	28	If. Location (Street City or Town, St		ural Route Number,
	To the Hospital or Attending Is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C		Physician: To the best of my known aminer: On the basis of examinating and manner stated.						
	To the To the comp	Me	29b. Signature and title of certifier	MULANA		29c. Licens			Date signed (Mont	
	15		P	X I W X WD			4347	10	2-16-	2004
•	r		30. Name and address of person with Neeraj Chopra	o completed cause of death (Ite a., M.D. P.O. Bo			ersbura. MG	20883		
•	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign		Spork				

RUTH

GREENFIELD,

State of Maryland / Department of Health and Mental Hygiene 00 1 - For Stata Registra 12/8L Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30, 2004 **Physician** December GEISBERT 12:30 A M FERN ESTELLE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth ADLII Day, Birthplace (State or Foreign County) Maryland 5 Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Yea<u>r</u>)912 Min. 92 Months Days Hours 1 □ M 2 🗓 F 216-48-6909 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any hijury or other traumatic avaration." 10c. City. Town or Location 10d. Inside City Limits 10h County 10a, State 1 ☐Yes 2V No Frederick Completed by Funeral Director Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4501 Baker Valley Road 21704 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗓 No Specify: Specify: ·White 3 Zwwidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry McComus Roderick Eula Irene Norwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Geraldine G. Krantz/Daughter 1820 Shookstown Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mt. Olivet Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jan. 4, 2005 Frederick, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enterted book a 5/bg, Cottra dia Straspatry, arrest ederick, Mopro Interval etween Onset and Death Immediate Cause (Final Conjustive heart Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner decense arther Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a considence of): Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐Unknown butonin 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural s after ob. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD. December 30, 2004 D54636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed W. Haque, M.D., 700 Montclair Avenue, Frederick, MD 21701 2. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 42185 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 28, 2004 **Physician** Deborah Hill Lvnn 6:10am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 467 West South Street Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr 8, 1 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 215-90-5751 Maryland Director 41 1963 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner near be notified at Maryland Frederick Director 1 √Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 467 West South Street 21701 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced Year or Dates: "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If Itam 27 is marked other tha any injury or other traumatic event. Itam Technician Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Talbot Sr Snoots JoAnn Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael D. Hill, Sr/Husband 467 West South St, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donatjon 5 ☐ Other (Specify) Smithsburg Crematory Dec 31,2004 Smithsburg, Maryland Foneral Service Livers 21. Signatua 22. Name and Address of Facility Reeney & Basford P.A. Funeral Home M00706 106 East Church Street, Frederick, Maryland 21701 Shock, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Morbid Obesity 10 Years resulting in death) /Medical Due to (or as a consequence of): **Examiner** Obstructive Sleep Apnea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): Box 68760, physicien Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant al time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 3 ☐ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2X No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page certilicate 1 ☐ Yes 2√ No To the Hospital or Atlanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred After 1x Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eron, m J D41717 December 28, 2004 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) Richard G. Yeron, M.D., 186 Thomas Johnson Dr, #203, Frederick Maryland 21702-4479 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar

**ORIGINAL** 

			State of Maryland / Department of He	ealth and Mer	ntal Hygie	ne a a i	10100
			1 - For State Registrar Certificate of D		Reg.	2004	42186
	Physici	an	1. Decedent's Name (First, Middle, Last)	2.	Date of Death	Day, Year	3. Time of Death
	/Medic	al	Mary Alice Hartman	1000		24 2004	12:30PM
_	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L 12800 Growdenvale Dr. NE Cumberla			4c. County of Death Allegan	3.7
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		Date of Birth (Month, Day, Ye		Y place (State or Foreign ntry)
١.	Director		122-03-8244 12 M 24X 83 Yrs.	4	/1/192		York
	fand ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	a-f sh	tor	MD Allegany Cumberland				1 ☐ Yes 2 ▼ No
	or 28	Dire	10e. Street and Number 10f. Zip Code 12800 Growdenvale Dr. NE 21502			Citizen of What Cou	ntry?
	eath w	Funeral Director				JSA 14. Race - Ameri	can Indian
<b>.</b>	after d	Fun	Armed Forces? If Yes, specify Cuban, 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No		an, etc.)	Black, White,	
003	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other than "neturel", or Items 23a or 28a-f show marked other than "neturel", or Items 23a or 28a-f show matic event, it is the light Evan in er mant the notified at	d by	3 Wildowed 4 Divorced Year or Dates:	Specify:			ite
5	in 72	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired)	uring most of working	166	o. Kind of Business/In	dustry
Maryland 21215-0036	d with giene.	oml	Elementary/Secondary (0-12) College (1-4or 5+) Retired		Ş	Secretar	Y
2	e d ta	Be		18. Mother's Name (F		•	
Z	should be nd Mental   marked o umatic eve	2	Archibald McNeill  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street an	Floy (Lo	·		Codo
Z	nd 2 sho alth and 27 is ma r treum		Harry M. Hartman Husband 12800 Growder				
ore,	es 1 a of Hez fitem		20a. Method of Disposition  1 Neurol 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)			. Location - City or To	
Baltimore,	Pag ment ent: I ury o		'4 Donation 5 Dother (Specify) ROCKY Gap Vet Ce				
Ba	permit. Departs Import eny inj		27. Signature of Foneryl Service Licensee 22. Name and Address 1302 Natt				vice 21502
	Tale 1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.		NAC THE REAL PROPERTY.		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a. Demender A A I I	zho, me	ers 7	ype	Chron.C
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			/	
		je.	Sequentially list conditions, and the sequential sequence of the sequence of t				=======================================
Vi	actre)	Examiner	that initiated events				
760,	ate be exectively, hysician and the burial-transit	ical Ex	resulting in death) Last  Due to (or as a consequence of):				
687	ficate g phys		d.				
ŏ	eath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of delive	*
В	The law requires that the death certificate be exected. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	Physician/Med	in the past 12 months?  1			Month	Day Year
<u>.</u>	uires that the dei signed by the a id be detached f	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
rds	w requires been sign should be	ed by			1 🗆 Yes	2 □ No 3 □ Prob	pably Minknown
ecords,	ne law re has bee ge 2 sho	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
<u> </u>	: The cate h	Com			performed 1 ☐ Yes 2 🔀	? death?	2 No
Division of Vital	Physicien: r this certifica ral director, p	o Be	examiner? Hospital: Other	26. Place of Death (C		o Clau	
0	g Phy er this eral d		27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury a	4   Nursing Home	d. Describe how in	e 6 □Other (Specit njury occurred	<i>y)</i>
ion	Attending or death. ector: After by the fune	atlo	2 ☐ Accident investigation M 1 ☐ Ye	es 2 🗆 No			
<u>X</u>	Jor Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street City or Town, St	t and Number or Rura tate)	d Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time	a, date and place, and	due to the cause	e(s) and manner as s	tated.
	he Ho in 24 f he Fu pletely	Medical	(Check only	nion, death occurred a	at the time, date	and place, and due to	the cause(s)
	with To T	Σ	29b. Signature and title of certifier  29c. License r			Date signed (Month,	
			30. Name and address of pers in who indeted cause of death (Item 23a) (Type, Print)	++76	DE	Cember	2/2004
	10	1	Solvat Road Was 912 Saton De Cu	inhacta.	nd h	Cember	0 <del>5</del>
¥	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	- 1 May 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1			
DH	Registi 4H 17 Rev 1/2		JAN 0 6 2005 Mesen & Aparte				
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ORIGINAL

		5	State of Maryland	d / Depart	ment of Health	and M	ental Hyg	iene		
	•	1 - For State Registrar		Certi	ficate of Deati	h	R	ag. No.	004	42187
Physic	an	1. Decedent's Name (First, Middle, Last)					<ol><li>Date of Dear Month</li></ol>	th Day	Year	3. Time of Death
/Medi Exami	cal	NELLIE YOUNG DA		NDERSON 4	b. City, Town, or Location	n of Death	12	02 4c. C	2004 County of Dea	3:50 a <sup>M</sup>
Exami		Hartley Hall Nursi	ng Home		Pocomoke Ci	ty			orcest	
Funeral Director		5. Social Security Number 6. Sex 1□	- A6		f Under 1 Year If Under 1 Year If Under 1 Year Indicates	er 24 Hrs. Min.	8. Date of Birth (Month, Day 08/08/1	1908	C	thplace (State or Foreign cyland
and w		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Locat	ion					10d. Inside City Limits
Maryli f sho	इ	MD Worceste	r Poc	omoke C	i tv					1XYes 2 □ No
h the or 28a e noti	Director	10e. Street and Number	100	Ornore C.	10f. Zip Code		1	10g. Citiz	en of What C	ountry?
ath wi	rai	1006 Market Stree			21851	211212	" "	1.	USA	
paritimity in the Marylant A. I. I. J. 2005.  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exame and outside an any injury or other traumatic event, the Medical Exame and must be rediffied at aging.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	<ul> <li>12. Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ul>	i	s Decedent of Hispanic Ces, specify Cuban, Mexic Yes 2 <mark>%</mark> No <i>Speci</i>		city Yes of No- Rican, etc.)		4. Race - Am Black, Whi Specify: W	
2 hou atura		15. Decedent's Educ	cation	16a. Deceden	t's Usual Occupation d of work done during m	oct of working	20	16b. Kin	d of Business	/Industry
ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired)	iost of Workii	<i>'</i> 9		1 4 1	
led willed will her th		12 17. Father's Name (First, Middle, Last)	2	Nur		ther's Name	(First, Middle,		lthcare	9
d be fi	o Be	Edward Washingto	n Young		Mar		more		,	
al yid should ind Men s marke umatic	၉	19a. Informant's Name/Relationship (Ty)		19b. Mailing	Address (Street and Num			r, City or	Town, State,	Zip Code)
and 2 aalth a n 27 is		Edward James Daugh		A STATE OF THE PARTY OF THE PAR	Old Snow Hi		-			
Pages 1 nent of He int: If iten		20a. Method of Disposition 1 XBurial 2 Cremation 3 R	emoval from State	•	ory or other place)	_	10		ation - City or	
Definition Pages Department of Mportant: If i my injury or once.		*4 □Donation 5 □Other (Specify)  21. Signature of Fun → I Service License				12/4/2	1			ity, MD
Dermi Depa Impo		21. Signature of Further Service Literase	2 4 - 2	HÔI 103	lame and Address of Fac Loway Melso Linden Ave	n'Fune	eral Hor	ne, ] ∵itv	P.A. MD 2	1851
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	n. Do not enter	the mode of dying, such	as cardiac o	r respiratory arr	rest,	110 2	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	urosepsi	2						Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ							324
Laminer	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence).		LUMONIA					3 DAY).
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a conseq	uence of):						
or our	dical	L.	J							
X 00 certifica iding ph	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ancy				2:	3d. Date of de	livery
wrequires that the death certifica been signed by the attending ph should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		ctopic pregnancy Other (specify)				Month	Day Year
that the od by detac		Part II. Other significant conditions con	ntributing to death but not res	ulting in the und	erlying cause given in Pa	urt I.	23e. Did to	bacco us	e contribute t	o the cause of death?
Ords, requires that een signed be dete	ed by	CORONARY A	RICKY DISCHU	Ę			1 🗆 Y	es 2 🛚	1N6 3□P	robably 4 Unknown
2 g g G	Completed	ADVANCED	DEMENITA				24a. Was a		prior to	utopsy findings available completion of cause of
The The Sate his page	Com						perfor 1 ☐ Yes		death?	
OT VICAL P Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other		(Check only of			- 22.)
	To To	27. Manner of Death	1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	28c. Injury at Work?		me 5 🗆 Resid 28d. Describe h			эспу)
Attending Phradestrick of the funeral by the funeral	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monin, Day Year)	Injury	M 1 □ Yes 2	□No				
LIVISION Attention after deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree y)	t, factory, office		28f. Location (S City or Tow		Number or P	lural Route Number,
DIVI  Hospitel or Al  124 hours after of Funeral Directed in by	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death o	occurred at the time, date stigation, in my opinion, o	and place, a death occurre	and due to the ded at the time, d	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)
To the within 2. To the I	Me	29b. Signature and title of certifier			29c. License number		-		_	th, Day, Year)
				PAL, MD	0006217	2		(2	12/20	04
T 2		30. Name and address of person who co								
	tate	Sharad Satyal - 1 31. Date filed (Month, Day, Year)	604 Market St 32. Registrar's Signa	reet, Po	ocomoke City	y, MD	<del>21851</del>			
Ponic		DEC 0.3.2	nnal Maria	12 R	10 All 9					

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar Amended#2			attricate of Death			
			Decedent's Name (First, Middle,		J, K312/229 &	amount of Dodge	2. Date of Death	ng. No.	3. Time of Death
	Physicia /Medic		Tina Pauline	Grimes Hugh	es		December	20, 2004	16:45 99
	Examin		4a. Facility Name (If not institution,			4b. City, Town, or Location of Death		4c. County of Death	
		•	12731 Catoctin			Thurmont		Frederio	
	Funeral Director		213-80-4473	6. Sex 7. Ao 1 ☐ M 2 1 1 7 7 Ao	ge (In yrs. last birthday, 43 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, June 3,	Year) 9. Birth Cour 1961 Penn	place (State or Foreign ntry) sylvania
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	Mary -f sho	tor	Marvland Frede	rick	Emmit	tsburg			1 <b>⊠</b> Yes 2 ☐ No
	r 28a	Irec	10e. Street and Number	LICK		10f. Zip Code		g. Citizen of What Cou	
	23a c	aiD	5 West Main Str	eet		21727	U	nited State	es
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, Inc. Modical Examinations to other traumatic event, Inc. Modical Examinations to other traumatic event, Inc. Modical Examinations.	d by Funerai Director	11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces od 1 ☐ Yes 2 150 If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2☆No Specify:	pecify Yes or No- Pican, etc.)	14. Race - Ameri Black, White, Specify: W	
5-0	72 h "natu	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	king	6b. Kind of Business/In	dustry
121	filed within Hygiene. Ithar than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ursing Assistant		Healthc:	
	filed Hygi othar ant, I	a	17. Father's Name (First, Middle, L	ast)			ne (First, Middle, M		are
an	should be and Mental I smarkad or umatic eve	To B	James Grimes, J	r.		Soniia	Wolfe		
Maryland	2 short		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Maili	ing Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip	Code)
	and sealth m 27		Lisa Hughes / S:	ister		FSK Highway, Keym			
Baltimore,	Pages 1 ment of H ant: If ita ury or ott		20a. Method of Disposition  1 XXBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (So			3/ 0 1	iber 23,	rederick, M	
Balt	permit. Departr Imports any inji		21. Signature of Farton Service L	icensee	Re 95	2.Name and Address of Facility 2.Sthaven Funeral S 501 Catoctin Mtn.	ervices, Hwy. Fre	Skkot Cody derick, MD	P.A. 21701
			23a. Part1. Enter the disease, of shock, or heart failure. List of	complications that cause nly one cause on each f	d the death. Do not en	ter the mode of dying, such as cardiac			Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	-		RINE TUMOR	OF LU	NG	Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):				
	LAGIIIIICI	10	Se wentially list conditions	b	a consequence of):	·			
	rted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c) as	a consequence or,				
Ć,	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of);				
68760	ysicia ysicia			d					
-	rtificat ng phy as th	Medical	IF FEMALE:						
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetaf death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
Records, P.	uires that the de signed by the a Id be detached t	by	Part II. Dther significant condition	ns contributing to death t	out not resulting in the u	underlying cause given in Part I.		acco use contribute to the	
COL	w requir been si should	Completed					24a. Was an	24b. Were auto	psv findings available
Re	The lav	ошь					autopsy perform	prior to co ed? death? 1 Yes	psy findings available impletion of cause of
Vital		BeC	25. Was case referred to medical	S		26. Place of Dea	1 ☐ Yes 2. th (Check only one		STEEN STORES
of V	Physician: this certific al director,	To	examiner? 1  Yes 2 No	Hospital:		nt 3 DOA Other: 4 Nursing H	ome 5 🗆 Resider	nce 6 🐼 Other (Specif	Mother's Residence
n o	ng l	on:	27. Manner of Death  1 Natural 5 Pending		ury 28b. Time o ay Year) fniury	of 28c. Injury at Work?	28d. Describe how	w injury occurred	
isio	r Attandir er death. ractor: Al by the fu	icati	2 Accident investigation investigation and accident investigation accident investigation and accident investigation accident investigation accident investigation accident acc	ot be 280 Place of In	jury - At home, farm, st	M 1 Yes 2 No	28f Location (Str	eet and Number or Rura	al Pouto Number
Division	l or A after Dirac	Certification:	4 Homicide determin	building, e	tc. (Specify)	reet, factory, office	City or Town,		noute Number,
	To the Hospital or Attantwithin 24 hours after deall To tha Funaral Diractor: completely filled in by the	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner sl	of examination and/or in	th occurred at the time, date and place, twestigation, in my opinion, death occur	and due to the car red at the time, da	use(s) and manner as s te and place, and due to	tated. the cause(s)
	ro the vithin ro tha	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month,	Day, Year)
	->-0			MD		D0056314	Pe	ELEMBER 2	21,2001
	0.		30. Name and address of person w		death (Item 23a) (Type,	Print)			
	P		01.400	ORGE 46		s JOHNSON FR	EDERICK	1/10/21	102
E	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2	2 2004 32. Regist	rar's Signature	Society)			

		•	_ FOI	artment of Health and Men	tal Hygiene 0 (	04 42189
	Division		Decedent's Name (First, Middle, Last)		Date of Death Month Day	3. Time of Death
	Physicia /Medic		William Crawford Hill		ecember 18,	2004 0757 MM
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County o	
	Funeral		Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hagerstown If Under 1 Year   If Under 24 Hrs.   8, [	Date of Birth	ington  9. Birthplace (State or Foreign Country)
П	Funeral Director		521-22-5431		Month, Day, Year) g 14, 1921	Country) Kansas
	D >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	oation		10d. Inside City Limits
	Aanyla F shov	ō	Maryland Frederick Braddock			1 ☐ Yes 2 ☐ No
	28a-f	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of W	
	3a or	Ö	6912 Potomac Ave	21714	United	States
	deatl	ner		Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica	1 , , , , , , , , , , , , , , , , , , ,	- American Indian,
36	or it	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	Specify:	
ö	72 hours after death with the Maryland naturel', or items 23a or 28a-f show dical Examinat must be indiffed at	ed b	3√ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent	dent's Usual Occupation	16b. Kind of Bus	
7.	n na	plet	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	Tob. King of Dat	and a made of y
212	filed withln Hygiene. other then " ent, the Me	Completed		ilitation Counselor	State Go	vernment
pu	be file tai Hy d oth	Be	17. Father's Name (First, Middle, Last)		st, Middle, Maiden Sumame	a)
yla	2 should be and Mental Is marked o	ဂ္	William W. Hill	Unknown		7.0.11
Maryland 21215-0036	d2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Type, Print)  Stewart Whitney Hill/ Son  P.O.	ng Address (Street and Number or Rural Ro Box 312 Braddock H		
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event. The Medical Examiner must be rediffed at		20a Method of Disposition 20b. Place of Dispo			City or Town, State
OE	Pages nent of ont: If it		1 Burial 2 Cremation 3 Hemoval from State	k Crematory 12/21/2	004 Frederic	ck, Maryland
Baltimore,	perrii. Pages 1 an Depirtment of Heal Importent: If item 2 any injury or other once.			2. Name and Address of Facility Stauf 621 Opossumtown Pike		
	. 3		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart allug. List only one cause on each line.	er the mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between
r	Priysician		Immediate Cause (Final disease or condition AS PIRATION	2.3		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		21, 0	,
		<u>-</u>	Sequentially list conditions, if any leading to immediate  b. Unconditions Due to (or as a consequence of):	RUCTIVE PURMONA	IKK WISEASE	40×
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
o,	an an		resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	Physiclan/Medlcal	d			
9	death certifica attending ph d for use as th	Mec	IF FEMALE:			
Вох	death certific e attending p id for use as i	slan	in the past 12 months?	Ectopic pregnancy Other (specify)	23d. Date Mon	of delivery th Day Year
o.	0 0 0	ysic	1 Yes 2 No 9 Unknown	Total (Spoonly)		
<u>Q</u>	s that the ned by th e detache	by Pł	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contri	bute to the cause of death?
ırdş	w requires that s been signed k should be det				1 ☐ Yes 2 ☐ No	3⊠ Probably 4 □Unknown
Vital Records,	40 m CA	Completed			autopsy pr	ere autopsy findings available for to completion of cause of
= E	Th ate pag	Соп			performed? de 1 ☐ Yes 2 ☐ No 1	eath? □ Yes 2□ No
Vita	Physicien: The this certificate rat director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Ch		
of	dis dis	. To	1 ☐ Yes 2 ☑ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No	1 3 DOA 4 Nursing Home	5 Residence 6 ☐Othe  Describe how injury occurre	
on	Attending Ir death. ector: After by the funer	itlor	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division	l or Attendii after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		Location (Street and Number City or Town, State)	r or Rural Route Number,
Ö	rs after ai Dire	Cert	Tomas Building, Ge. 1000019)			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only one)  1   Certifying Physician: To the best of my knowledge, deatly not one to the property of th	vestigation, in my opinion, death occurred a	t the time, date and place, a	nd due to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number D 5 2 3 2 3	29d. Date signed	(Month, Day, Year)
)	+1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) out Ity m.	1 2174	2
	Sta	- 100	31. Date filed (Month, Day Year) 2 2 2004 32. Registrar's Signature	64× 44 15		
	Registr	ar	Jane Jane	A Comment of the Comm		

			For State Registrar	State of	Marylan		artmen rtificat					giene	2004	421	90
	Physici	an	1. Decedent's Name (First, Middle, L.						-		2. Date of De Month		Year	3. Time of	
	/Medic	al	Mildred			Hef	fner	T	Location o	( D 4 b	Decemb				1am <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, gi Frederick Memo						rick	or Death			County of Dea Frederi		
	Funeral		5. Social Security Number 6.	Sex 7.		last birthday)	If Under Months		If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. Bi	thplace (State ountry)	or Foreign
	Director		217-30-6317	1□M 2 <b>X</b> F		69 Yrs.	IVIOTITIS	Days	nouis	WIII.	May 8,	193	5		land
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	Mary Iled s	tor	Maryland Freder	ick	Fre	ederic	k							1 Tes	2 <b>X</b> ] No
	th the	Funeral Directo	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What C	ountry?	
	ath wi	ral	4405-C Mountville	· · · · · · · · · · · · · · · · · · ·				2170					U.S.A.		
	ter de Iteme	-une	11. Marital Status  1 ☐ Never Married 2 ▼ Married	12. Was Decede Armed Force 1 ☐ Yes 21	s?	.S.   13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi		
920	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes	2 <b>X</b> I No	Specify:				Specify:	White	
2-0	should be filed within 72 hours after death with the Maryland and Mentle Hygiene. I Hygiene when the mest show it marked other than "naturel" or iteme 23a or 28a-f show it marked other than "naturel" or iteme 23a or 28a-f show it marked other than "naturel" is Medical Exeminer must be notified at	Completed	15. Decedent's 8 (Specify only highest gi	ducation ade completed)		(Give	dent's Usua kind of wo	rk done a	lurina mosi	t of work	ina	16b. Kir	nd of Business	/Industry	
121	within ne.	mpl	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us	se retired,	)					/0	
Q 2	filed y Hygie other i		12 17. Father's Name (First, Middle, Las	t)		Воо	kkeep	er	18. Mothe	r's Name	e (First, Middle			ion/Cont	ractin
au	lid be lental ked c	To Be	Martin Luther Je	nkins							elia Pe				
Maryland 21215-0036	2 shou and N is man		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	al Route Numb	er, City or	Town, State,	Zip Code)	
	and ealth m 27		John H. Heffner/I	lusband	205 0	4405-	C Mou	intvi	lle I					land, 23	1703
altimore,	Pages 1 nent of H int: If iten iry or oth		20a. Method of Disposition 1	Removal from Sta	ua	lace of Dispo emetery, cre					Date		cation - City or		
<u>=</u>	permit. Page Department Importent: If any injury or once.		* 4 Donation 5 Other (Spec 21. Signature of Funeral Service Lice		St.	Paul '	S Cent 2. Name an			1/5/	2005	Jef		Maryla	
Ba	Department Department		P. Renn 7	ME Mille	an						Fimeral	Home		t Church ck, MD, 2	
	The law requires that the death certificate be executed  X  X  In the death certificate be executed  X  X  X  X  X  X  X  X  X  X  X  X  X	dical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arte Due to (or b. Due to (or	n line.	erotic uence of): uence of;					isease	rrest,		Approximal Interval Bet Onset and	tween
P.O. Box 6	that the death certifica ed by the attending pr detached for use as ti	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknow	1 2 ∏ Fetal tat time of d	Ideath 3	⊒Ectopic pr ⊒ Other (sp					2	3d. Date of de Month		Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions Morbid Obesity	contributing to deat	h but not resi	ulting in the u	nderlying c	ause give	ın in Part I.					o the cause of c	
000	e law requir has been si je 2 should I	Completed	Sleep Apnea								24a. Was			utopsy findings completion of c	
œ _		Com	Chronic Hyperte	ension							perfo	rmed? 2 <b>X</b> No	death?		ause of
/ita	h <b>ysicien:</b> The la nis certificate ha I director, page 2	Be	25. Was case referred to medical examiner?					045		of Death	(Check only o	one)			
o	Attending Physicien: r death. ector: After this certific: by the funeral director, t	. To	1 Yes 2 No 27. Manner of Death			ER/Outpatier 28b. Time o	-	8c. Injury	4 1140	-	me 5 Resi			ecify)	
O	nding th. : Afte	itlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of I (Month,	Day Year)	Injury	М	Work	:? /es 2 🔲 1						
Division of Vital Records,	al or Attending I after death. I Director: After d in by the funer	Certification;	3 Suicide 6 Could not determined	286. Place of	Injury - At ho etc. (Specify	ome, farm, st	reet, factory	, office			28f. Location ( City or Tox	Street and wn, State)	d Number or A	ural Route Num	iber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical C	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exe	hysician: To the be miner: On the basi and manner	s of examina	wledge, deat tion and/or in	h occurred vestigation	at the tim	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s	s)
	To tl withi To tt	M	29b. Signature and title of certifier	7 1	~ ~	^	290	License					signed (Mon		
	١		mall	16/1	/ V			D351	L04 			nec	ember	30, 200	4
	W		30. Name and address of person who Andrew Zarick,					Stro	ot I	Trod.	orick i	Mary	land 21	701-450	11
	Sta	te	31. Date filed (Month, Day, Year)	en Dec	atrada Ciana	di com		OLLE	۱ وات.	read	LICK	aLy.	Lailu ZI	. / UT-47(	/ <b>L</b>
	Registr		JAN 0 6 200		J. K	Good	ED.								

UNK 04-404 04-08036 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 14 per fb. 2839 1-6-04 vt legible and Martel Hurians.

DALIA	HADTD		For State	State of Maryland Department of Health and	Mental Hygie	ne 10101
DALIA	HARIK		Registrar	Certificate of Death	Reg.	
	Physicia /Medic		1. Decedent's Name (First, Middle	HARIR		Day Year 14, 2004 10:00a. M
	Examin	er	4a. Facility Name (If not institution,			4c. County of Death
			RT.50 & RT.201	landover  6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs		prince georges
	Funeral Director		5. Social Security Number  10 AUAIIADIE  Usual Residence of Decedent	6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign
	ryland show	_	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	with the Maryland is or 28a-f show	Director	10e. Street and Number	1R-17X SPRINGHELD	10a.	1 ☐ Yes 2 No  Citizen of What Country?
	ath with 23a or ust be		8110	Kenova LN 2215	3	AIGERIA
	fter dez r Items iirer	Funeral	11. Marital Status  1 Never Married 2 Marri	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
0036	hours a	þ	3 ☐ Widowed 4 ☐ Divorced			Specify: white
7.	hin 72 l	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	nking 16b	. Kind of Business/Industry
21,	lled with		17. Father's Name (First, Middle, I	STUDENT	me (First, Middle, Maid	EDUCATION
200	uld be fi flental h rked of	To Be	ABDEL	KRIM HARIR FAT	THA P	BOUKEMIDJA
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralla Hygeins. Integrating the Maryla Important: If item 27 Is marked other then "neturel", or Items 23a or 28a f show enty injury or other treumetic event. It a Marilla Examinational Examinational Examinational Engineers.		19a. Informant's Name/Relationsh	ip (Type, Print) FATH - 19b Mailing Address (Street and Number or R	ural Route Number, Ci	ty or Town, State, Zip Co (e)
	of Heal		20a. Method of Disposition 1 ☐ Burial 2 Cremation	20b. Place of Disposition (Name of A cemetery, crematory or other place)	Date 20c	Locati - City or Town, State
i to an interest of the control of t	It. Pag rtment rtent: I njury o		'4 □ Donation 5 □ Other (Sp. 21. Signatur Funeral Service L	pecity) TEKING KALLY 12	17.04 57	ERLING, VA
å	Deparimi Deparimi Impo		21. Signatur Profesional Service I	1 STERLING	F3 4103	Sterling Sterling
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each line		) Approximate Interval Between Onset and Death
•	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Gunshit wound of head Due to (or as a consequence of):		
	Examiner	_	Sequentially list conditions,	b		
7/7	uted d ansit	Examiner	cause (Disease or injury that initiated events	Due to (or as a consequent of):		
G	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):		
69760	) = D &	edical		d.		
ä	ath cert	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
0	the dea	Physician/M	1 ☐ Yes 2 ☐ No 9 X Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Jay Tour
Q	The law requires that the death certifule is a required by the attending table 2 should be detached for use a	þ	Part II. Other significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.		co use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown
	w requi	leted			1 ☐ Yes	
Division of Vital Decords		Completed			autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 12 Yes 2 \( \subseteq \text{No} \)
× its	VICION: Icion: Sertific Sector,	Be	25. Was case referred to medical examiner?	11 i-b	ath (Check only one)	
ď	Phys or this eral dir	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 2 28b. Time of 28c. Injury at	Home 5 Residence 28d. Describe how i	e 6 Nother (Specify) Scene
	anding sath. or: Afte	atio	1 Natural 5 Pending	ation Found 12/14/04 Fund 4:45 M 1 Yes 2) No	Subject	shot
	or Att after de Directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	200 Place of Injury. At home form street feeting office	28f. Location (Stree City or Town, S	tand Number or Aural Route Number, tate) Runte Soj mute 201
	To the Hospital or Attending Physicien: Within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical C	(Check only 2 X Medical	g Physician: To the best of my knowledge, death occurred at the time, date and plac examiner: On the basis of examination and/or investigation, in my opinion, death occ	e, and due to the caus	
	ro the vithin 2 o the complet	Med	one) 29b. Signature and title of certifier	and manner stated.  29c. License number	29d.	Date signed (Month, Day, Year)
	F 5 F 0		> Zalvin	ellech Al- O.C.M.E.	DEC	CEMBER 15,2004
			30. Name and address of person	who completed cause of death (Item 23a) (Type, Print)  111 PENN STREET I	BALTIMORE.N	1ARYLAND 21201
	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Segistrar's Signature	,	

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
	Physicia /Medic		John H. Johnson, Jr.  December 20 2004 12,42 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		•	223 Belle Hill Road, Room 219 Elkton Cecil
	Funeral Director		5. Social Security Number 6. Sex 1 March 19 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 11 March 18, 1948 II1 inois
	σ		Usual Residence of Decedent
	anylan show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	he Ma	Director	Delaware New Castle Wilmington
	with t	DI	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  814 West 5th Street 19805 United States
	death ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "natural", or Itams 23e or 28e-f show event, I're Mexilical Exertifier i ust be multired at	by	Armed Forces? 1966—  1 Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces? 1966—  1 Yes, specify Cuban, Mexican, Puerto Rićan, etc.)  1 Yes, specify Cuban, Mexican, Puerto Rićan, etc.)  Black, White, etc. Black  Specify: American Indian
5-0	72 ho 'natur	Completed	15. Decedent's Education  16a. Decedent's Usual Occupation  (Specify only highest grade completed)  16b. Kind of Business/Industry  (Give kind of work done during most of working
121	within ene. than "	mpl	Elementary/Secondary (0-12)  College (1-4or 5+)  2  College (1-4or 5+)  Assembler  Automobile  Manufacturing
d 2	e filed within It Hygiene. other then	e Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	should be nd Mental markad c	O B	John H. Johnson, Sr. Nona Welters
ary	~ = 6 3	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	es 1 and 2 should of Health and Mer f itam 27 la marke r other traumatic		John H. Johnson, III/Son 1968 Lakeview Road, Wilmington, Delaware 19805
Baltimore,			20a. Method of Disposition  1 Aburial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of Disposition (Name of December place)  20c. Location - City or Town, State December  20c. Location - City or Town, S
Balti	permit. Page Department of Important: If any injury or once.		21. Signiture of Funeral Service Licensee  22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921
	· 6		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between
M	Priysician		Immediate Cause (Final disease or condition a. 15 CV D
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):
		-e-	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):
1.5	uted d ansit	Examine	cause. Enter Underlying Chuse (Disease of Apry) that initiated events  c.
o,	e exectan an an arial-tr		resulting in death) Last  Due to (or as a consequence of):
68760,	licate be executed physician and s the burial-transit	edical	d
	_ 0)	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
). Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physiclan/M	1 Live birth 2 Fetal death 1 Glectopic pregnancy 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 1 Pregnant at time of death 2 Pregnant at time of death 1 Pregnan
P.0	that the de ted by the a		9 Unknown  Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Vital Records,	v requires t been signe should be	ted by	1/2 Yes 2 No 3 Probably 4 Unknown
Reco	0 - 0	ompleted	24a. Was an autopsy performed? prior to completion of cause of death?
tal		e Cc	1   Yes   2   No   1   Yes   2   No     No     Yes   2   No   Yes
<u> </u>	Physician; this certific ral director,	To B	examiner?  1D Yes 2 No
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work?
sio	Attending r death. actor: After by the fune	catl	2 Accident investigation M 1 Yes 2 No
Division	tal or Attenders after deatlal Diractor:	Certification:	28e. Place of Injury - At home, farm, street, factory, office determined determined building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or a within 24 hours after To the Funeral Direct completely filled in b	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To t To t	Σ	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)  Pecember 20, 2004
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  U. Farkas, MD. Hulan Help, Elkton, MD 2192/
	Sta	_	
	Registr	ar	JAN 0 6 2005  Sure Mark Signature  JAN 0 6 2005

		1 - For State Registrar	<del></del>			and / De <sub>l</sub>	ertificate	e of D	eath		,	Reg	g. No.	UUL	Thall
Physic /Medi		1. Decedent's Name (First, Mi		onsch	er						Mon	of Death th nber	Day 15,	Year 2004	3. Time of Death 4:00A M
Examii		4a. Facility Name (If not institutional Independence	_			ille	Ну	Town, or Li	7ille	2				inty of Dea .ce Ge	orges
uneral irector		5. Social Security Number  577-18-5456  Usual Residence of Decedent		ex □M 2⊠F		yrs. last birthda 94 Yrs.	Months		If Under a	Min.	8. Date (Mon Feb.	of Birth th, Day, 1	(ear) 910	9. Bir Co Vir	thplace (State or Foreigi puntry) ginia
fed at	tor	10a. State 10b. Cou	nty	eorges		City, Town or									10d. Inside City Limits 1 X Yes 2 □ No
a or 28a	Direc	10e. Street and Number				119 0000	10f. Zip					100	g. Citizen	of What Co	ountry?
order than "natural", or items 23e or 28e-f show event, it e Modical Execution must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 M 3 Widowed 4 Divor	Married	12. Was De Armed I	2 🔯 No Sive	in U.S. 13	3. Was Deced If Yes, spec	_		gin? (Sp i, Puerto	ecify Yes Rican, et	or No-	14. F		
han "natur e Medicel	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1 12	ghest gra	de completed	(1-4or 5+)	16a. De (Gi life	cedent's Usua ive kind of wor e. DO NOT us	rk doné dui se retired)	on ring most	t of work	ing	16		f Business	•
marked other than	To Be Co	17. Father's Name (First, Midd Robert Dame	dle, Last)				Homen				e (First, M		aiden Surr	Own Ho	ome
Important: If item 27 is marked any injury or ther traumatic ev	-	19a. Informant's Name/Relati		•			ailing Address Uongf								
ury or the		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremati 4 ☐ Donation 5 ☐ Othe			- 01-1-	Metropo	rematory or of	ther place)	L	ec. 2004	Date 16,	- 1		on - City or adria	Town, State
any inju		21. Signature of Funeral Serv	Lien	till			22. Name an 2222 Wi							_	. 20007
sician		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final	, or comp List only	plications that one cause or	caused the	death. Do not e	antor the mode		arrob an	oardiao.	or rocoira				Approximate
		disease or condition		a. Athe		erotic						ntory arres	, , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death Years
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aminer	ai Examiner	disease or condition	{	b. Due to	rosc1e o (or as a con	erotic						tory arres			Interval Between Onset and Death
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			_ For	1 10030		f Maryland						•		-	421	01.
			1 - State Registrar				Ce	rtificate	of D	Death			Reg. No.	. 0 0 %		
	Physici	an	1. Decedent's Name (Fi		_							2. Date of Dea	ath Day	2 And	3. Time of D	
	/Medic Examin		David Sim  4a. Facility Name (If not			mber)		4b. City, 7	Fown, or I	Location o	of Death	DEC	4c.	2004 County of De		
	LXdIIIII	ic.	7101 Bayf						apol					nne Ar		
	Funeral Director		5. Social Security Number 557–12–44	er 6. S		7. Age (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min,	8. Date of Birt (Month, Da June 2	y, Year)	9. B	irthplace (State or F Country) 'alifornia	≃oreign 3.
	land ow		Usual Residence of Dec 10a. State 10	b. County		10c. City,	Town or Lo	ocation							10d. Inside City	Limits
	a-f sh	tor	Maryland	Anne	Arundel	Ann	apoli:	S							1 □ Yes 2	: No
	or 28	Funeral Director	10e. Street and Number	r				10f. Zip					-	zen of What	•	
	eath v	eral	7101 Bayf	ront D		18 edent Ever in U.S	3. 13		21403		gin? (Spe	cify Yes or No		ted St	ates	
စ	after d		1 Never Married	2 Married	Armed Fo 1 ☐ Yes If Yes, Gi	orces?					, Puerto F	cify Yes or No Rican, etc.)		Black, Wh		
003	ural', c	d by	3 □ <b>¼</b> Vidowed 4 □		Year or D	oates: 1943-	1946	1 Yes 2		Specify:					nite	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ther than "natural", or Items 23a or 28a-f show ant, the Medical Examinat must be notified at	Completed by	(Specify o		ade completed)		(Give	dent's Usua kind of wor DO NOT us	k done di	urina most	t of workin	g	16b. Kir	nd of Busines	s/Industry	
212	e filed within al Hygiene. I other than ' vent, the Me	mo	Elementary/Seconda	ry (0-12)	College (	1-4or 5+)	Met	eorolo	ogist	<u> </u>			U.	S. Gov	vernment	
nd	be file sta! Hy od othe event.	Be	17. Father's Name (Firs	t, Middle, Last	)							(First, Middle,	Maiden	Sumame)		
ryla	should nd Men marke umatic	은	Frank Day				10h Maili	na Addross	(Street 2)			imonds Route Numbe	or City or	Town State	Zin Codal	
Ma	and 2 sho ealth and n 27 Is m		Farl L. I				i .	•	-			nnapoli	-			
ore,	of Health of Health litem 27		20a. Method of Disposit	tion			ace of Dispo	osition (Nam matory or ot	e of			ate			or Town, State	
Ē	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 ☐ € `4 ☐ Donation 5 ☐	Other (Speci	JHemovai from fy)			e Cre							ore, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy origing to other traumatic event, the Medical Experiment must be notified at ORGS.		21. Signature of Funera	Service Lice	Row	melu									cal Home, s, MD 214	
			23a. Part1. Enter the d shock, or heart fa	ilure. List only	one cause on	caused the death. each line.	. Do not en	ter the mode	of dying	, such as	cardiac oi	respiratory as	rest,		Approximate Interval Betwe Opset and De	
	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	al	a	zheim		lisea	se						5 year	
И	Examiner			ſ		(or as a consequ	ence ot):									
	# = = = = = = = = = = = = = = = = = = =	ner	Sequentially list conditi if any, leading to imme- cause. Enter kinderlyin	ions, diate	b. Due to	(or as a consequ	ence of):									
	be executed sician and burial-transit	Examiner	Cause (Disease or inju- that initiated events resulting in death) Last	ry	c.	(or as a consequ	ence of):									
760,	ite be ex iysiclari ne burial	calE		l	d —	(0. 40 4 00.004										
89	tificate ag phy as the	4000														
Вох	ires that the death certificate signed by the attending phys d be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 more		1 Live I	tcome of pregnar pirth 2 Tetal	death 3[	⊒Ectopic pre					2	3d. Date of d	elivery Day Yea	ar
P.O.	he des	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregi 9□ Unkn	nant at time of de lown	ath 5[	☐ Other (spe	ecity)						,	
	s that t ned by a detai	by Ph	Part II. Other significan	nt conditions	contributing to d	eath but not resu	lting in the u	ınderlying ca	ause give	n in Part I.		23e. Did to	obacco u	se contribute	to the cause of dea	ith?
rds	w requires been sign should be		None									1 🗆 1	res 2)	<b>(</b> No 3□	Probably 4 Uni	known
Vital Records,	e la has	Completed							_					24b. Were prior to death'		allable se of
ital		BeC	25. Was case referred examiner?	to medical								(Check only o	ne)			
of V	S S =	2	1 □ Yes 2 X No			Inpatient 2 E			A Othe	r: 4 □ Nu		ne 5 Resid			ecify)	
on (	ding Phy h. After thi funeral o	tlon	27. Manner of Death  1 Natural 5 2 □ Accident	Pending investigation		of Injury oth, Day Year)	28b. Time o Injury	M Zi	8c. Injury Work¹ 1 □ Y	at ? ′es 2.⊟l		8d. Describe l	iow injury	occurred		
Division	f or Attendate after death	ertification;		Could not to	28e. Place	of Injury - At hor ing, etc. (Specify,	me, farm, st	reet, factory				8f. Location (S City or Tov			Pural Route Numbe	W,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	0	29a. Certifier 1	Certifying P	hysician: To the	e best of my knov	viedge, deat	th occurred a	at the time	e, date an	d place, a	nd due to the	cause(s)	and manner	as stated.	
	he Ho in 24 h he Fu pletely	edical	one)		miner: On the b and man	pasis of examinati ner stated.	ion and/or in				th occurre					
ı.	with To t	Σ	29b. Signature and title	1 1	W.				. License		20		-		nth, Day, Year)	r
•			30. Name and address		Km²z		23a\ /T····-		ULC	974	20		Ve	c 18,	2004	
			CHARLES	1. KINZ	LER MD	3059	1/1/1/	ON RD	A	NNA	POLIS	MD	214	03		
	Sta		31. Date filed (Month, I	Day, Year)	32. F	Ajistrar's Signat	ure			,			· · · · · ·			
	Regist	al	טו	EC 20	2004	Carried '	N A									

	1 - For State Registrar	State of Maryland /	Department of H		ygiene 2004	42195
Physiciar /Medica	1. Decedent's Name (First, Middle, Last)	NIA KUPISC	34	2. Date of D Month December	Peath Day , Year .	3. Time of Death
Examine	4a. Facility Name (If not institution, give s	ROAD	4b. City, Town, or	oN .	4c. County of Death Baltmon	12
Funeral Director	5. Social Security Number 6. Sex 187302/66	M 2 AF	Yrs. If Under 1 Year Months Days	Hours Min. 8. Date of B	9. Birthe Cour	place (State or Foreign PA
Maryland -f show	10a. State 10b. County		ton		1	10d. Inside City Limits 1 ☐ Yes 2 No
3a or 28a-f sl	10e. Street and Number 1401 Monkton F	Road	10f. Zip Code 2111	.1	10g. Citizen of What Cour	ntry?
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at TO Bo Completed by European Discrete.	3 X Widowed 4 ☐ Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ▼ No	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.) Specify:	Black, White,	
Maryland 21215-0036 d 2 should be tiled within 72 hours at tith and Mental Hygjene. 77 is marked other than "naturel", or traumatic event, the Medical Exam To Be Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ia. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired) SSembly Lin	uring most of working	16b. Kind of Business/In Light Bull Manufactu	b
© 8 m ≥ 0	17. Father's Name (First, Middle, Last)	'		18. Mother's Name (First, Middle Dora McWi	e, Maiden Surname)	Ling
2 5 € 5 ±	19a. Informant's Name/Relationship (Type Roy C. Warfel/S			nd Number or Rural Route Number.n St., Hamps		•
altimore, mit. Pages 1 ac partment of Hea portent: If Item y injury or other	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other) (Specify)	emoval from State Dula	of Disposition (Name of tery, crematory or other place iney Valley norial Gardens	Dec. 29,	20c. Location - City or To	
Baltimor permit. Pages Department of Importent: If it any injury or o	21. Signature of Ameral Salvice Lice 11		J.J. Hart	s of Facility Censtein Mort Ld St., New F	uary, Inc.	17349
Physician /Medical	23a. Part1 Enter the disease, or complished, or hart failure. List only on Immed the Caure (Final disease or curition resulting in death)	cations that caused the death. Do cause on each fine.  Due to (or as a consequence	o not enter the mode of dying Vlas Accident	, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
execued ial-trar sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):			
cate be execu ed physicien and the burial-trar sit		Due to (or as a consequenc	e of):			
the death certiful the attending the attending the attending the attending the as as the attending the attending the attending the attended for use as	D	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	ery Day Year
cords, P. wrequires that been signed b should be deta	Hugostonor		in the underlying cause give		tobacco use contribute to the	
Vital Records, sicien: The law requires the certificate has been signe rector, page 2 should be decorded.				24a. Was auto peri 1 □ Yes	opsy prior to con	psy findings available mpletion of cause of
	examiner?	ospital: 1  Inpatient 2 ER/0	Dutpatient 3 DOA Othe	26. Place of Death (Check only  4 Nursing Home 5 Res		
Division of tel or Attending Phy is after death. el Director: After this ed in by the funeral ded in by the fu		28a. Date of Injury (Month, Day Year)	. Time of 28c. Injury Work M 1 🗆 Y	at 28d. Describe ? ′es 2 □ No	how injury occurred	
Division  To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification		28e. Place of Injury - At home, building, etc. (Specify)		City or To	(Street and Number or Rura own, State)	
To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier 12 Certifying Phys (Check only 2 Medical Examinate)	ician: To the best of my knowled her: On the basis of examination a and manner stated.	ge, death occurred at the time and/or investigation, in my op	e, date and place, and due to the inion, death occurred at the time	cause(s) and manner as st , date and place, and due to	ated. the cause(s)
To T with To T	1 m	redlardir, my	29c. License Maryla	4 028723	29d. Date signed (Month, )	, . ,
10	30. Name and address of person who co	mpleted cause of death (Item 23a	ON N. CHARU	STREET SUT	E5105 BAC 212	C MD
State		32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month DEC. 25°, **Physician** 2004 10:55AM ELIZABETH MARY KELLEHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WALDORF CHARLES 5018 DOCTORFISH CT. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG • 27, 1958 Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 20X 46 Yrs Director IRELAND 213-39-3041 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic evant, the Maylical Examinar must be notified at 1 Yes No Director WALDORF MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 U.S.A. 5018 DOCTORFISH CT. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø ‰ If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXo Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 MEDICAL ADMIN. SECRETARY DOCTOR OFFICES permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If I em 27 is marked othe any injury or other traumatic evant, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANCES TWOMEY WILLIAM JOSEPH KELLEHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN HENRY YOUNG-HUSBAND 5018 DOCTORFISH CT., WALDORF, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition IRELAND -COBH, COUNTY CORK ST.COLMAN'S CEM. 12-31-04 21. Signature of Funeral Service Licensee M00479 22. Name and Add RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final VARIAM ANCE Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached the 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Munknown 3 Probably 1 ☐ Yes 2 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 No 1 Yes 217 1 🗌 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending 1-Thatural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death 6 Could not be determined 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation in my entired, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar				i / Depa		t of H	ealth a	and M	lental Hygi			42197
			Decedent's Name (First,	Middle, Last	)							2. Date of Deat	1		3. Time of Death
	Physici		Elaine	SI	nirley	Kn:	auer					Month Decembe	Day	Year	1:24 p.m.
	/Medio Examir		4a. Facility Name (If not ins				4401	4b. City,	Town, or	Location of	of Death	Decembe	4c. County		11.24 p.m.
	Xdiiiii		St. Mary	's Hos	spital				Le	eonar	dtow	n	St.	Mar	v † s
	Funeral		5. Social Security Number	6. Se		Age (In yrs. Ia	st birthday)	If Under	1 Year	If Under	24 Hrs.			9. Birth	place (State or Foreign
	Director		344-20-4362	10	ом жДГ	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birth	928	Cou	llinois
	D.		Usual Residence of Decede												
	thow	_	10a. State 10b. C	•			Town or Lo								10d. Inside City Limits
	the Marylar 28a-f show	cto	MD St	. Mar	y's	Me	chanie	csvil.	Le						1 Yes 2 No
	or 28	Oire	10e. Street and Number					10f. Zip	Code			10	g. Citizen of V	Vhat Cou	ntry?
	23a	ai	28685 Hanco	ck Dr	ive				206	59			Unite	d St	ates
	ems ems	Inei	11. Marital Status		12. Was Decede	ent Ever in U.S	3. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spa	ecify Yes or No- Rican, etc.)	14. Rac		can Indian,
98	or It	by Funeral Director	1 Never Married 2		Armed Force 1 ☐ Yes 2 If Yes, Give	ĎNo		1 ☐ Yes 2				, ,			
215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show its Madical Examinational be notified at	d b	3 AWidowed 4 ☐ Div		Year or Date	es:								Whi	
Ŋ	"nat	Completed	15. De (Specify only	cedent's Edu highest grad	cation e completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	k done o	ation <i>Juring m</i> os	t of worki	ng	6b. Kind of Bu	ısin <i>e</i> ss/ln	ndustry
12	han han	ш	Elementary/Secondary (0	-12)	College (1-4	or 5+)		nemake		)				Own 1	U om o
121	iould be filed within Mental Hygiene. Parked other than		17. Father's Name (First, M	iddle Last)			1101	i cina k	-1	19 Mothe	arte Name	(First, Middle, M			HOME
Ĕ	be f	Be								TO. IVIOLITE	n s Name	(First, Mildale, N	aiden Suman	(6)	
Maryland	should be filed within 72 hours after dea nd Mantal Hygiene. I marked other then "naturel", or Items umatic event, the Macical Experient re	L L	George Gunth		una (Daima)		405 14-30-		/O4 4 -		_	ta Strig		0	0.11
Mai	12 sho h and 7 Is ma treum		19a. Informant's Name/Rel					_				I Route Number,	-		
ຜົ	and tealth m 2		Renee Ware/ 20a. Method of Disposition	Daugh	ter	20h Bis	28	3685 B	lance	ock D		,Mechani			
0	ges t of t		1 Burial 2 Crem	ation 3 🗆 F	Removal from Sta	ate, Ce	ace of Dispo metery, crei	natory or o	her place	9) D	ec.2	9.2004	Oc. Location -		
Ë	tment tant:		`4 □Donation 5 □Ot		-	// Bri	nsfiel					-			te Hall, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show enty interpretation of other treumatic event, the Muchal Experiment rest be rediffied as once.		21. Signature of Funeral Se		*C/ox	X MO10	1111					ad, Leon			Home, P.A. D 20650
	155		23a. Part1. Enter the disea shock, or heart failure	se, or com	loations that sa	sed the death.	Do not ent	er the mode	of dying	g, such as	cardiac c	r respiratory arre	st,		Approximate Interval Between
	Physician	l	Immediate Cause (Final	. List only o	1	Urunira	at an	6 00	2.1						Onset and Death
	/Medical		disease or condition resulting in death)	-	a	as a conseque		Ceri	41						
	Examiner			- 1	Lung	Cancu	with	diffe	)en	refat.	an.n				
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		J	as a conseque	ence of):		-						
	d d ansit	Examiner	Cause (Disease or injury that initiated events	1	puln	nervan	ambo	1,0-	• •						
oʻ	exection and and rial-tr	Exa	resulting in death) Last		Due to (or	as a conseque	ence of):								
,160,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cal			d										
68	tificat g ph) as th			- 1											
Вох	andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregna	nt 2	23c. If yes, outco	me of pregnan		75-4					23d. Dat	e of delive	ery
œ	death e atte d for	cia	in the past 12 months 1 ☐ Yes 2 ☐ No	?	4□Pregnan	t at time of dea		Ectopic pro Other (sp					Mor	nth	Day Year
0	t the by th ache	hys	9 Unknown		9□ Unknow	n									
<u>a</u> .	res tha igned be det	by P	Part II. Other significant co	nditions co.	ntributing to deal	h but not resul	ting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use conti	ibute to t	he cause of death?
Ď	quire in sig uld b	pe			·							1 🗀 Ye	s 2 🗆 No	3 🗌 Prot	pably 4 Unknown
Records,	The law requires that the site has been signed by the bage 2 should be detache	Completed										24a. Was an	24b. V	Vere auto	ppsy findings available
Re	The lav	Ĕ										autopsy perform	ed?	rior to co leath?	impletion of cause of
			25. Was case referred to m	edical			<del></del>			00 Di	-4 D4b	1 Yes 2	23710	☐ Yes	2 No
5	Physicien: rthis certificant al director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	100	Hospital:	atient 2 E	R/Outpatier	t 3 🗆 DO	Othe			(Check only one ne 5 ☐ Resider		as /Consider	6-1
	ding Phyeicien:  After this certific funeral director,	. To	27. Many er of Death	-	28a. Date of (Month,		28b. Time of		Bc. Injury Work			28d. Describe how			y)
Division	Attending it death. ector: After by the fune	tio		ending vestigation	(Month,	Day Year)	Injury	м		:? /es 2 ☐	No				
is:	Attendil death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ G	ould not be	28e. Place of	Injury - At hon	ne, farm, str	eet, factory	office			28f. Location (Str.	eet and Numbe	er or Rura	al Route Number,
Di	after Dire	Certification:	4 Homicide	0(0111111100	building	, etc. (Specify)		,				City or Town,	State)		
	spite ours nerel filled	C	29a. Certifier 1 Ce	rtifying Phy	sician: To the be	est of my know	ledge, death	occurred a	at the tim	e. date an	d place. a	and due to the ca	use(s) and ma	nn <i>e</i> r as s	tated
	24 h 24 h 9 Fur etely	Medical	(Check only 2 Me	dical Exami	ner: On the basi	s of examination	on and/or in	estigation,	in my op	inion, dea	th occurre	ed at the time, da	te and place, a	and due to	o the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of c	ertifier	1 .1	^ .		29c	License	number		29	d. Date signed	(Month,	Day, Year)
	->-°		1/11	Mah	1KALI	-604	773		1)0	060	47	2	12/2	6/1	·
d'	A.C.		30. Name and address of p	arson who	ampleted cause	of death /line	23a\ /T	-			. /	/	1-0	12	304
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State of Maryland / Department of Health and Mental Hygienes For State Registra 42198 Certificate of Death Ang. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician SHEILA MARIE KENDALL **DECEMBER 15, 2004** 11:45 A<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 313 HEMSLEY DRIVE QUEENSTOWN QUEEN ANNE'S If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Yea Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F 275-40-6895 59 Director JAN. 13. 1945 OHIO Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits notified at Director 1 Yes 2 No MD QUEEN ANNE'S QUEENSTOWN 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Modical Examinar must be a 313 HEMSLEY DRIVE 21658 death USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed by If Yes, Give 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 ELEMENTARY SCHOOL PRINCIPAL **EDUCATION** 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filk tment of Health and Mental H; tant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN WARNER 9 EVELYN WIGDON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES KENDALL/HUSBAND 313 HEMSLEY DRIVE, QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 = 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. CHESAPEAKE CREMATORY 12/17/2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Squamous Metastatic Cell Corcinoma of the Esophagus months /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of). Examiner the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) Yes 2 No detached the the 9 Unknown 9 Hinknown ģ The law requires that been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 ☐ Yes 2 ☒ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 🌠 Residence 6 ☐ Other (Specify) ٩ 1 ☐ Yes 2 ☑ No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After ↑ Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital or hin 24 hours a 29a. Certifier 🖄 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To the 29b. Signature and tella of certified 29c. License number 29d. Date signed (Month, Day, Year) ٥ avid Coerber D0062144 December 17, 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID 401 NORTH BRODGING BALTIMORE MD GERBER JOHNS HOPKINS HOSPITAL 21231-2410 31. Date filed (Month, Day, Year)
DEC 2 0 32. Registrar's Signature State 200 Registrar

Laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show and incomplete and items of the marked other than "natural", or Items 23e or 28e-f show and items and items of the marked other than "natural", or Items 23e or 28e-f show and items and items of the marked other than "natural", or Items and items of the marked other than "natural", or Items of the marked oth		Prick  Pr	ge (In yrs. last birt 89 10c. City, Town Fr	or Location  ederick  13. Was Decelif Yes, spe 1 Yes  Decedent's Usu  Give kind of willie. DO NOT L	Fred ri Year Days  Code  21702  dent of Hicry Cuba 22 No		Death  C  Min.  S		Day Year 18, 2004 4c. County of De Frederi Year) 9. B 2, 1915 Ka	4:05 P Anath  ck  inthplace (State or Foreign Journty)  10d. Inside City Limits  1  Yes 2 Note to the country?  States  merican Indian,
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death or dea	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		e of pregnancy 2  Fetal death at time of death	3 □Ectopic p 5 □ Other (s					23d. Date of de Month	elivery Day Year
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	* * what ~	1 Lant	m	_// т	-139	971		De	cember 2	2004
,	30. Name and address of person who	completed cause of	death (Item 23a) (		,- <u>1</u> 0;	<i>7</i>   1		рe	cember 2	20, 2004
	Robert L. Kaufr	\ \			th S	St	Fred	lerick	, MD 217	01
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	Physicia /Medic		Decedent's Name (First, Middle JOAN MARIE	, Last) KUGLER				2. Date of De Month DECEMBE	Day	Year 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution	, give street and number)		4b. City, Town,	or Location of	Death	4c. Cour	nty of Death	
			SPA CREEK NURS		- (	ANNAPO		M Hrs. Lo. Day of Dis		NE ARUI	
	Funeral Director		5. Social Security Number 016-28-3618 Usual Residence of Decedent	6. Sex   7. Age (In yr	s. last birthday) Yrs.	Months Days		Min. 8. Date of Birt (Month, Da AUG 6			lace (State or Foreign try) SACHUSETTS
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Ë	Pages nent of int: If it		1 X Burial 2 ☐ Cremation  1 Donation 5 ☐ Other (S	pacifu) Lit	AKEMONT	matory or other pla MEMORIA	L 1	2/20/2004	DAVIDS	ONVILI	LE, MD
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2' any injury or other once.		21. Signature of Funeral Service					ROBERT E.			AL HOME, 20715
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Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		_ Ot	har	of Death (Check only o			
on of	ding Ph h. After th funeral	tion; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin 2 Accident investic	28a. Dale of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju	4   1401	sing Home 5 Resid			)
Division of	= Sign	ertification;	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	not be Geo Blood of Injury - At	home, farm, str cify)			28f. Location (S City or Tow		mber or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edicai C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of my k Examiner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the t vestigation, in my	ime, date and opinion, death	place, and due to the on occurred at the time, o	cause(s) and r	manner as sta e, and due to	ated. the cause(s)
	Within To the comp	Me	29b. Signature and title of certified	ouil wo		29c. Licen	se number	8	29d. Date sign	ned (Month, E	Day, Year)
•			20 Name and address of second	7	nm 22a) (T	Deint)	100	0	14/1	0166	707
			Stravt E	who completed cause of death (It		900	Best	gate Au	Mapa	los, L	104 Mai 2140/
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2	0 200/	nature	book		,			

			1- For Amend Item 23b-dept. If per phy 6841 3-1-05 tas Certificate of Death	ental Hygie	ene 004	42201
	Physici	an.	Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
	Physici /Medio		JOSE DEJESUS LENG	DEC 2	2 2004 Year	3:00 P M
	Examir	ier	4a. Facility Name (If not institution, give street and number)  NATIONAL NAVAL MEDICAL CENTER  4b. City, Town, or Location of Death BETHESDA		4c. County of Death	MEDV
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	MONTGO	
	Funeral Director		060-36-1105	8. Date of Birth (Month, Day, Y APR - 30	(ear) Coul	place (State or Foreign htry)
	pu ,		Usual Residence of Decedent	1111(100)		
	faryla shov	ŏ	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1 ☐ Yes 2 ☐ No
	the A	Director	MARYLAND CHARLES WALDORF  10e. Street and Number 10f. Zip Code	100	J. Citizen of What Cour	
	3a or	D	6 TADCASTER CIRCLE 20602	109	U.S.A.	my.
	death	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
98	or Ite		1 Never Married XXMarried XXMYes 2 No Specify:	nican, etc.)	Black, White,	
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Jical Eva cher must be to diffed at	ed by		10	CU	BAN
15	- 4 6	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	ing	b. Kind of Business/In	austry
212	filed within Hygiena.	Som	Elementary/Secondary (0-12)  College (1-4or 5+)  12  MASTER SERGEANT	τ	J.S. AIRF	ORCE
pu	be filed within 72 hours after death with the Marylan Ital Hygiena id other than "natural", or Items 23a or 28a-1 show event, Ita Madical Evanine Finast be ricilled	Be (		e (First, Middle, Ma		
yla	should be filed within and Mental Hygiena.  rmarked other than umatic event, Ire M.	10		ANGELA		
Maryland 21215-0036	2 g in 19		19a. Informant's Name/Relationship (Type, Print)  TAEKO N. LENG - WIFE  6 TADCASTER CIRCLE			0602
ē,	is 1 and 3 of Health item 27 other tr				c. Location - City or To	
Ë	m O		¹\$\int\text{Spurial 2 \subseteq Cremation 3 \subseteq Removal from State} \ `4 \subseteq Donation 5 \subseteq Other (Specify) \ ARLINGTON_NATIONAL CEM.Ol-	-21-05 A	ARI. INGTON	. V 7
Baltimore,	permit. Page Department of Importent; If eny injury or once.		21. Signature of Juneral Service Licensee M ( ) 4 7 9			/ VA
8	89 = 9		RAYMOND FUNERAL  LA PLATA, MARYLY  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			
			shock, or heart failure. List only one cause on each line.	or respiratory arrest		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  aAVOXIC ENCEPHALOPATHY			Onsot and Death
	Examiner		Due to (or as a consequence of):			
	.,	Jer	Sequentially list conditions, frank, leading to him, date cause. Enter Underlying Cause, Obisease or injury  Congestive Heart Failure			
N.C	acuted nd transi	Examiner	trat initiated events C			
8760,	The law requires that the death cartificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Due to (or as a consequence of):  Community Acquired Pneumonia			
9	eath certific attending pl	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	atten atten 1 for u	cian	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of delive Month	Day Year
Ö.	at the de by the a tached	hysi	9 □ Unknown			
S, P	es tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the	
ord	sen si	ted	Coronary Artery Disease, Hypertension	1 🗆 Yes	2 No 3 Prob	ably 4 DUnknown
Vital Records,	elawr hasbe je 2sh	Completed	Hyperlipidemia	24a. Was an autopsy	prior to cor	psy findings available impletion of cause of
al F					d? death? I No 1 ☐ Yes	2□ No
Ζ̈̈́	sician: T certificat irector, pa	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2♥ No  26. Place of Death Content of the spital: 1 ☐ Minpatient 2 ☐ EP/Outpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ DOA Content of the spital: 1 ☐ Minpatient 3 ☐ D		- C TO# 10 11	
ō	g Phys er this eral dii	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	me 5 🗆 Hesidenc 28d. Describe how	e 6 Other (Specify injury occurred	/)
ion	ath. r: After re funera	atio	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
Division of	el or Attendi s after death. el Diractor: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
Ω	spitel or Al ours after o nerel Dirac filled in by		CO. Continue Vicantinia Divisional Divisiona			
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of my death occurred at the time, date and place, a construction one)	and due to the caus ed at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the To the Comp	Me	29b. Signature and fittle of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
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	44				DICAL CENT	ER
	Sta	te.	31. Date filed (Month, Day, Year) 32. 9 gistrar's Signature	MD 20889	-3000	
	Registr		JAN 0 6 2005 Berein & Jane			

			1 - For State Registrar	State of Ma	aryland		artment of F		nd Ment		ene 3. No. 2 0	04	42202
	Physic		Decedent's Name (First, Middle, La  DAV				LONG		N	ate of Death lonth	Day	Year	3. Time of Death
	/Medi Exami		RAY  4a. Facility Name (If not institution, given	DASHIELL e street and number)			LONG 4b. City, Town, or			embe	4c. County	of Death	1836
1	23000		PENINSULA REGIONA	Medical	Co	VAN	540	1564	4		1	Icom	100
	Funeral		5. Social Security Number 6. S	ex 7. Ag		ast birthday)	If Under 1 Year Months Days	if Under		ate of Birth Month, Day, 1	rear)	9. Birthpi	ace (State or Foreign try)
	Director		218-34-7834 Usual Residence of Decedent	201	66	Yrs.			API	RIL 16	,1938	MARY	ĹAND
	aryland show		10a. State 10b. County		10c. City	, Town or Lo	cation					10	Od. Inside City Limits
	the Mar 28a-f sh	ģ	MD WICOMIC	)	TY	ASKIN							1 ☐ Yes 2 No
	with the Maryland a or 28a-f show Loe notified at	Olre	10e. Street and Number				10f. Zip Code			100	g. Citizen of W	/hat Coun	try?
	death w	ral	4301 TYASKIN ROAL				2186				USA		
Maryland 21215-0036	or Ita	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Tes 2 An If Yes, Give Year or Dates:	Ever in U.S lo	1	Vas Decedent of H f Yes, specify Cuba □ Yes 2 No	ispanic Origi in, Mexican, Specify:	in? (Specify Y Puerto Rican	es or No- , etc.)		- America k, White, o	atc.
2-0		Completed	15. Decedent's E (Specify only highest gra	ducation			lent's Usual Occupa		a fi usa di in a	16	Bb. Kind of Bu	siness/Ind	ustry
21	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5		life. L	kind of work done o DO NOT use retired	)					
121	iled w dygiei ther ti		12 17. Father's Name (First, Middle, Last,			HEAVY	EQUIPMEN				CONSTRI		N
and	ges 1 and 2 should be filed within 72 ho t of Health and Mental Hygiene. If item 27 Is marked other than "netu or other traumetic event, Ita M. dica	o Be	MAURICE			LONG				t, Middie, Ma	iden Sumami		
Z	should nd Men marka umatic	2	19a. Informant's Name/Relationship (	Type, Print)			g Address (Street a	MARY and Number		te Number (	City or Town		SHIELL
	and 2 saith a n 27 is		GYPSY LONG- WIFE				TYASKIN					Stato, Zip	0000)
Jre,	ss 1 and 2 of Health litem 27 I		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of natory or other place		Date	-	c. Location - (	City or To	wn, State
<u>"E</u>	Page nent d ant: If ury or		1 ☑Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State  /)		-	EMETERY	1	2-20-2	004 т	YASKIN	MAT	RYI.AND
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Euneral Service Licer	isee //			Name and Addres				ERAL HO	OME	CILIMID
_	6 5 5 G		TIJERISE F	of House	cel		5 E MAIN				Y, MD 2	21804	
	Physician /Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Athero	selen	otic (	er the mode of dying			iratory arres	t,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a	a consequ	ence ot):							•
	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequ	ence of):							
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a	consequ	ence of):							
9	ifficate g phy: as the	0		. d									
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the line of the li	2 Fetal	death 3	Ectopic pregnancy Other (specify)				23d. Date Mon		y Day Year
	ires that signed b d be deta	by P	Part II. Other significant conditions of					n in Part I.	2	3e. Did toba	cco use contril	bute to the	cause of death?
rds	w require been sig should b	ed t	Type I	Deuletes	me	Mitos				1 🗌 Yes	2 □ No :	3 🗌 Proba	bly 4 Unknown
Vital Records,	e taw re has be ge 2 sho	Completed	Hyperter	Dealestes					2	4a. Was an	24b. W	ere autop	sy findings available
2		Com	11						11	autopsy performe ☐ Yes 2 ☐	d? de	eath?	pletion of cause of □ No
/ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						of Death (Che				
of	Phys this al dii	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Inpatier		P/Outpatient		4   Nurs	,		e 6 □Other		
o U	ding After fune	Certification:	1 Platural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injury Work	at ? ′es 2 ⊡ No		escribe how	injury occurre	d	
Division	Attendi r death. sctor: A by the fu	flca	3 ☐ Suicide 6 ☐ Could not be		ry - At hon	ne, farm, stre		00 2 110		cation (Stree	et and Numbe	r or Rural	Route Number,
D	el or safter	Serti	4 Homicide determined	building, etc	. (Specify)		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Ci	ty or Town, 5	State)		
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifier 1 ← Certifying Ph (Check only one) 1 ← Medicel Exam	ysicien: To the best of iner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at the time estigation, in my op	e, date and p inion, death	place, and du occurred at the	e to the caus he time, date	se(s) and man and place, ar	ner as sta nd due to t	ted. he cause(s)
	To t Com	Σ	29b. Signature and titte of certifier				29c. License				Date signed		ay, Year)
•	( D		1 Kil	) ws			0	2498	6	12	417/0	4	
	Smt		30. Name and address of person who Achert I. Reilly 1	completed cause of de	eath (Item :	23a) (Type, F	Salish Span	7 me	d 2180	)/			
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)  DEC 2 0	2004 32. Registra	r's Signatu	ire B	Spork	2					

		1 – For Stata Registrar	State of M	arylan		artmen rtificat				F	Reg. No.	004	4220
Physicia /Medic		Decedent's Name (First, Middle, I Brenda Joyce Lee	е							2. Date of Dea Month Decembe	r 14,		3. Time of Death
Examin Funeral	er	4a. Facility Name (If not institution, g  20217 New Hamps)  5. Social Security Number 6	nire Ave.		last birthday)	Brin If Under	klow 1 Year	Location of	24 Hrs.	8. Date of Birt	Мо	nt gom	
Director		269-46-8435 Usual Residence of Decedent	1□M 2¶F	63	Yrs.	Months	Days	Hours	Min.	June 22	, 1941	Ohi	0
ne Marylar 8a-f show	Director	Maryland Montgom	ery		y, Town or Lo								10d. Inside City Limits 1X Yes 2 □ No
ified within 72 hours after death with the Maryland Hygiene. Hygiene, sther is not used than brancher is now ent, the Madical Exeminer mest be multified at	by Funeral Dire	10e. Street and Number  20217 New Hampsh  11. Marital Status  1 □ Never Married 2√ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?	7			20862 lent of Hi			ecify Yes or No- Rican, etc.)	10g. Citizen o U: 14. R B	SA ace - Amer lack, White	ican Indian,
d within 72 hours af giene. er than "naturel", or the Madical Every	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed)  College (1-4or	5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired,	uring mos	t of worki	ng	16b. Kind of	Business/In	
9 7 2	To Be C	17. Father's Name (First, Middle, La Denzel Dillard						Wilh.	elmir	(First, Middle, na Davis	5		
1 and 2 s Health ar em 27 ie ther treu		19a. Informant's Name/Relationship  Leamon Lee— Spou  20a. Method of Disposition  1 ∑ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	Se □Removal from State		20217 Place of Dispo	New osition (Name of the land	Hamp ne of ther place	shire	e Ave	Brink  2. Brink  2. Brink  2. 2004	10W N	10 201 1 - City or T	362
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lice								es-Rina Ave. S			Home g, MD 2090
Physician /Medical Examiner  Pe priviper removit  Per priviper rem	ical Examiner	23a. Part1. Énter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, litary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as	rdiac rdiac a conseq nal	c Arrequence of): Insuff	icien	су						Approximate Interval Between Onset and Death
ut the death certifical by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	I death 3	⊒Ectopic pr ⊒ Other (sp						Date of deliver	very Day Year
vrequires that been signed should be de	by	Part II. Other significant condition	s contributing to death t	out not res	ulting in the L	inderlying c	ause give	on in Part I		23e. Did to	′es 2XΩNo	3 □ Pro	the cause of death? bably 4 □Unknown opsy findings available
- Fe od	e Completed	25. Was case referred to medical						OS Place	of Dooth	autop	med? 2 X No	prior to co death? 1  Yes	ompletion of cause of
Phys	ToB	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigal	Hospital: 1  Inpati 28a. Date of Inju (Month, Date)		ER/Outpatier 28b. Time of Injury		8c. Injury Work	r: 4□ Nu	ırsing Ho	me 5 <b>X</b> Resid	lence 6 🗆 O		ify)
	Certification:	3 Suicide 6 Could no 4 Homicide determine				reet, factory	, office			28f. Location (5 City or Tow		nber or Rur	al Route Number,
HOS Fur Pe	edical		Physician: To the best taminer: On the basis of and manner st	of examina						ed at the time, o	date and place	e, and due t	to the cause(s)
To the within 2 To the Complete	Σ	29b. Signature and title of certifier	Fyn MD	)		D:	30110	number			29d. Date sign		. Day, Year) 5, 2004
!		30. Name and address of person what Antonio Fojo, M. 31. Date filed (Month, Day, Year)		ckvil	lle Pil	ke 10			r. B	ethesda	, MD 20	0892	
Sta Registr		DEC 20		مقي	19	20	arks	and a					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42204 State of Maryland / Department of Health and Mental Hygiene 10 10 4 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Moore Alice Mae 29, December 2004 12 Noor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Northampton Manor Nursing Home Frederick tt Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Fe Month, Day, Birthplace (State or Foreign County Land 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2/□ F 90 Director 217-10-9615 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, toside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examinar must be notified at Frederick 1 X Yes 2 No Frederick Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 U.S.A. 1000 Heather Ridge Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritat Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Item any injury or other traumatic event, the Medical Exemples 2008. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) Public School System School Crossing Guard 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lea L. Spurrier Tyler Toms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 434 Girard Street, Gaithersburg, MD 20877 Larry T. Moore/Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Mt. Office Cemetery Jan. 4, 2005 | Frederick, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Keeney & Basford Funeral Home Kuland (.( 23a. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate types of the control of the contr Approximate Interval Between Onset and Death tmmediate Cause (Final HEMRT ATHERO SCLETOTIC DISEASE HYDERTENSIVE" **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE To THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): attending physician a foruse as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown been signed to should be deta Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☑ No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

the Hospitel or Attending within 24 hours a To the Funerel D

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

one)

29b. Signature and title of certifier

1142

31. Date filed (Month, Day, Year)

814 Toll House Ave., Frederick, MD 21702 Sibte A. Kazmi, M.D., Registrar's Signature

29c. License numbe

00 4795

29d. Date signed (Month, Day, Year)

12-30-2004

. H.D 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

			1 - For State Registrar	State of Maryla		artment of F		Reg	ene 200	7 to to C
	Physici /Medi	cal	Decedent's Name (First, Middle, L     FLORENCE EVE      4a. Facility Name (If not institution, g.)	LYN MURRAY		4h City Tour	or Location of Dea	T.	Day Year 26, 2004	
ė,	Examir Funeral Director	ner	GENESIS LA PL	ATA CENTER	s. last birthday) Yrs.	LA	PLATA	. 8. Date of Birth		
	the Maryland 28a-f ehow notified at	rector	Usuel Residence of Decedent  10a. State 10b. County  MARYLAND CHAR  10e. Street and Number		City, Town or Lo	PLATA  10f. Zip Code			. Citizen of What C	10d. Inside City Limits 1 X Yes 2 □ No
-0036	thin 72 hours after death with the Maryland e. en "naturel", or Items 23a or 28a-f ehow Mardical Examiner must be notified at	ed by Funeral Directo	1 MAGNOLIA DRI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12, Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Specify:	Specify Yes or No- to Rican, etc.)	U.S.A.  14. Race - Ame Black, White	encan Indian, le, etc. WHITE
nd 21215-0036	be filed within 72 tal Hygiene. d other then "na"	Be Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las	College (1-4or 5+)	(Give	bent of work done bo NOT use retired	during most of wo	rking 16l	OWN HOM	
, Maryland	12 should h and Men 7 ie marke treumatic	ToE	AUGUST HENRY G  19a. Informant's Name/Relationship  DAVID MURRAY S	(Type, Print)	19b. Maili			ural Route Number, C		Zip Code)
Baltimore,	nit. Peges 1 artment of Hoorent; if iter injury or oth		20a. Method of Disposition  **EBurial 2	□Removal from State ify) 20b.	Place of Dispo cemetery, created EDAR H	osition (Name of matory or other place ILL CEM 2. Name and Addre	ETERY 1	2-30-04	BALTIMO	Town, State
n	Physician /Medical Examiner		23a. Pent1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused the dear yone caused neach line.  Due to (or as a conse	ath. Do not en	A PLATA	, MD 2	SERVICE 0646 cor respiraty arrest,		Approximate Interval Between Onset and Death
1, '09/8	sate be executed bhysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)						
O. Box 6	the death certificate y the attending phys sched for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes No 9  Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnancy Other (specify)	,		23d. Date of del Month	ivery Day Year
cords, P	n requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac 1 ☐ Yes		the cause of death?
паі нес	The lay ate has page 2	e Completed	25. Was case referred to medical	T			00 80 40	24a. Was an autopsy performed	prior to death?	atopsy findings available completion of cause of
VISION OT VI	dis di	Certification: To B	examiner?  1 Yes 2 No  27 Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatier 28b. Time of Injury	28c. Injun Worl	er: 4 Nursing H	ome 5 Residence 28d. Describe how i		cify)
Ž N	spitel or Att ours after d nerei Direct filled in by i	al Certifl	4 Homicide determined	building, etc. (Spec	owledge, deatl	occurred at the tin	ne date and place	28f. Location (Stree City or Town, S	(ale)	stated
)	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter it completely filled in by the funeral	Medical	(Check only 2 Medical Exa	miner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time, date	and place, and due	to the cause(s)
	12		30. Name and address of person who	6 12 12	ATT.	Print) Y	N.D.	WALDO	oner, r	nd 2066+
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 0 6 2	33 Registrar's Sign	No Apr	wes				

			1 - For State Registrar		aryland / Dep <i>Ce</i>		ealth and N	Mental Hyg	giene,	4 42206
,	Physici /Medi		Decedent's Name (First, Middle, La     HARRY FRANK	MOLINARI		,		2. Date of Dea Month DEC	24 20	
·	Examir	ner	4a. Facility Name (If not institution, giv CIVISTA MEDI			4b. City, Town, or LA	PLATA		4c. County of I	
	Funeral Director		215-20-6573	Sex 7. Ag 1XIM 2□F	90 (In yrs. last birthday 78 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day SEPT.	3,1926	Birthplace (State or Foreign Country) MARYLAND
. ~	aryland show	7	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2€ No
-INAR	ith the Marylan or 28a-f show	Director	MARYLAND CHAR  10e. Street and Number	LES		WALDORF 10f. Zip Code			10g. Citizen of Wha	••
1 1	leath wi	Funeral D	11080 WEYMOUTH	12. Was Decedent	T. 323 Ever in U.S. 13.	206 Was Decedent of Hi		pecify Yes or No-	U.S	- A - American Indian,
7011	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinating the Indillised at	by	1 Never Married AMMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☒ No	Specify:	o Rican, etc.)	Black, \ Specify:	White, etc. WHITE
1	in 72 h	Completed	15. Decedent's E (Specify only highest gr	ade completed)	lifa.	edent's Usual Occupa e kind of work done of DO NDT use retired,	ition Juring most of wor )	king	16b. Kind of Busin	·
17	Naryland 2121 2 should be filed within 1 and Mental Hyglene. 1 is marked other than "	Com	Elementary/Secondary (0-12)	College (1-4or :		NER/FABR			SHEET M	
3	Maryland d 2 should be file th and Mental Hy? I's marked oth traumatic event	Be	17. Father's Name (First, Middle, Last HARRY MOLINARI					MANGUS	Maiden Sumame)	
2 R	Paryl and We is mark	T <sub>O</sub>	19a. Informant's Name/Relationship			ing Address (Street a	and Number or Ru	ral Route Numbe	-	
AF	e, M 1 and 2 1 ealth am 27 ithar tra		MARY LOU MOLIN  20a. Method of Disposition	ARI-WIFE	110		UTH CT.	,APT.3	23, WALD	ORF, MD20603
I	Pages ent of F nt: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cre	ematory or other place CHURCH C			PISCATA	
	Baltimore, Ma parmit. Pages 1 and 2. Department of Health at Important: If Item 27 is any injury or other trea		21. Signature of Funeral Service Lice	msee MOO47		22. Name and Addres RAYMOND LA PLATA	FUNERAL	SERVI	CE, PA	·
V	Physician // Medical Examiner partial in principle of principle in pri	cal Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	d the death. Do not exine.  a consequence of): a consequence of): a consequence of):	ater the mode of dying	g, such as cardiac	or respiratory are		Approximate Interval Between Onset and Death Only
	Records, P.O. Box 687 The law requires that the death certificate title has been signed by the attending physionage 2 should be detached for use as the	Physiclan/Medlc	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 15 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	□Ectopic pregnancy			23d. Date o Month	,
	ds, P. uires that to signed by tid be detailed.	by	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause give	en in Part I.		bacco use contribu	ite to the cause of death?
	Vital Recor	Completed						24a. Was a autop: perfor	sy prio mød? dea	re autopsy findings available r to completion of cause of th? Yes 2 No
	/ital	Be	25. Was case referred to medical examiner?	Hospital:		Othe	AC-	th (Check only or	ne)	
	Of Physical Christon	: To	1 Yes 2 No	1 Hospital: 1 Hopatii 28a. Date of Inju (Month, Da		ant 3 DOA	4   Nursing n		ence 6 Other (	Specify)
ē	Division of Vital Records,  To the Hospital or Attanding Physiclan: The law requires the within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed completely filled in by the funeral director, page 2 should be go	Certification:	1 SNatural 5 Pending 2 Accident Investigatic 3 Suicide 6 Could not I 4 Homicide determined	be 28e. Place of In	jury - At home, farm, s tc. (Specify)	M 1 🗆 '	k? Yes 2 □ No	28f. Location (S City or Tow		or Rural Route Number,
•	e Hospital 24 hours: a Funaral	Medical Co			of my knowledge, dea of examination and/or i ated.					
	To the within To the compl	Me	29b. Signature and title of certifier	Tilaha	m m	29c. License D-4	6046	2	29d. Date signed (A	Month, Day, Year) f - 2004
	10		30. Name and address of person who	ALĮKHAN	I MD.11	9, Print) 8 <u>LAGRAN</u>		X 1890	LAPLATA	MD 20646
	St	ate	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	and D	_			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day y Year 25/2004 **Physician** Ollie Mae McMillan 11:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, May 19), 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2X F 80 242-14-3863 Director North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itama 23a or 28a-f show the Modical Example remaintee notified at 10d. Inside City Limits Director 1 □ Yes 2 No Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 Monkton Road 21111 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð Black 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Material Elementary/Secondary (0-12) College (1-4or 5+ Machine Operator permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: If item 27 is marked other the eny injury or other traumetic even. Sterilization 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lee Choate Lillie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorenzo McMillan 903 L Swallow Crest Court, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Dec. 30, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, MD \* 4 Donation 5 DQther (Specify) 2004 22. Name and Address of Facility
J.J. Hartenstein Mortuary, Inc.
24 Second St., New Freedom, PA 17349 21. Signature of uneral rvice Liber ariensiem Prit1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GASTROINTESTINAL BLEEDING /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading limits and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the delached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 2 UROSEPSIS 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has certificate rmed? 2X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 X Natural safter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide hours after within 24 hours a To the Funaral L Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-25-04 Im. D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOO. M. D 31. Date filed (Month, Day, Year)

JAN 0 6 2005 7601 OSLER TOUSON, MARYLAND 3 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryland		ent of He			ene 2001	+ 42208
	Physici /Medic		Decedent's Name (First, Middle, Last)     Leonard Jerome M:					2. Date of Death Month December	Day Year 25, 2004	7:09 PM <sup>M</sup>
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give strated by St. Mary's Hospital 5. Social Security Number 214-58-4491		birthday) If U	Leonaro	Location of Death  1 town  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		
Maryland	-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland St. Mary		own or Location	Park			-794 1110	10d. Inside City Limits 1 ☐ Yes 2 X No
5-0036 72 hours after death with the Maryland	l', or Itams 23a or 28a xaminer must be noti	by Funeral Director	10e. Street and Number 47479 South Hampto		13. Was D	Zip Code 20653	panic Origin? (Sp , Mexican, Puerto Specify:		U.S.A.  14. Race - Am Black, Whi	encan Indian, ite, etc.
<b>21215-0036</b> od within 72 hours af	ene. than "natura he Medical E	Completed I	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion 10	life. DO NO	f work done du T use retired)	ırina most of work	ing 16	Bla b. Kind of Business  Educatio	s/industry
Maryland 2	Mental Hygie arkad othar atic avant, I	To Be Co	17. Father's Name (First, Middle, Last)  John Miles				18. Mother's Nam Elizabe	e (First, Middle, Ma	iden Surname)	
Baltimore, Mar permit. Pages 1 and 2 sho	Department of Health and Mental Hygiene. Important: or Itams 23a or 28a-f show Important: If itam 271s marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at 2008.		19a. Informant's Name/Relationship (Type  Marie Miles / Wil  20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Ren  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses	noval from State 20b. Place cerne	47479 S of Disposition etery, crematory les Mem 22. Nam	Outh Ha (Name of or other place Garde	ens 12-3	Date 20 31-04 Insfield	in ton Pa c Location - City of Leonardto Funeral H	rk, MD 20653 rTown, State wn, Maryland come, P.A.
Pr / E:	nysician Medical xaminer	iner	David A. Goff  23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First or thing Cause (Disease or injury)		on not enter the ansition confi:	mode of dying	, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death 12 Months
.O. BOX od/ou, the death certificate be executed	e attending p	Physician/Medical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence)  If yes, outcome of pregnancy  1 \( \text{Live birth} \) 2 \( \text{Fetal death} \)  4 \( \text{Pregnant at time of death} \)  9 \( \text{Unknown} \)	ath 3□Ectop	ic pregnancy (specify)			23d. Date of de Month	olivery Day Year
F ta	been signed by should be detac	þý	Part II. Other significant conditions contri	buting to death but not resulting	g in the underlyi	ng cause giver	n in Part I.			o the cause of death?
		Completed							prior to	utopsy findings available completion of cause of
VISION OF VICAL Attending Physician:	After th	ıtlon: To Be	1 193 2 7 140		Outpatient 3 December 1 December 2 December	DOA Other	· 4 🗆 Nursing Ho	me 5 Residence 28d. Describe how		ecify)
5 8	Dira	Certification:	3   Suicide 6   Could not be 4   Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				28f. Location (Stree City or Town, S	State)	
L To tha Hospital	within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier  (Check only one)  1	ian: To the best of my knowled COn the basis of examination and manner stated.	dge, death occur and/or investiga	red at the time tion, in my opi 29c. License	nion, death occur	red at the time, date	se(s) and manner as and place, and due Date signed (Mont	e to the cause(s)
34	0%		30. Name and address of person who com	plated cause of deeth filters CC	a) (Typo Brist)	D506	86		December	27, 2004
	Sta Registr		Gurdeep S. Chhabra		ary's Ho		Leonar	dtown, Ma	ryland 20	0650

			1 - State Registrar	State of Maryland / Do	epartment of F Certificate of			iene2 () () (;	42209
			Decedent's Name (First, Middle, Last)		· ·		2. Date of Death	1	3. Time of Death
	Physici		George Ellis Morn	ria			Month Decembe	Day Year r 18, 200	X *   1
	/Medic Examin		4a. Facility Name (If not institution, give str		4b. City, Town, o	or Location of Death	Decembe	4c. County of Dea	
1	LAdinii		46510 Walnut Court	t	Lexing	ton Park		St. Ma	rv's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign country)
i į	Director		229-34-6523 1 <b>0X</b>	M 2□F 75	s. Months Days	Hours Min.	(Month, Day, 08-27-1		irginia
	P .		Usual Residence of Decedent						
	irylar show	_	10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Ba-f.	cto	Maryland St. Mary	y's Lexing	ton Park				1 ☐ Yes XXNo
	다 다 Oc 24	i e	10e. Street and Number		10f. Zip Code		10	og. Citizen of What C	ountry?
	23a	a	46510 Walnut Cour		20653			U.S.A.	
	tem tem	une		2. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	72 hours after death with the Maryland Insturat, or Hems 23s or 28s-f show dical Examinat ha notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 👿 No	Specify:		Specify:	
21215-0036	hour tural	pa	15. Decedent's Educa		ecedent's Usual Occup	nation		16b. Kind of Business	White
15	in 72	ojet	(Specify only highest grade	completed) (	Give kind of work done ife. DO NOT use retire	during most of work d)	ing		
12	filed within Hygiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	rpenter			Construct	ion
	Hygid other	0	17. Father's Name (First, Middle, Last)		rpeneer	18. Mother's Name			
Maryland	ould be Mental	ToB	Ellis Morris			Virgin	ia B. Pa	yton	
ary	2 should and Men is marke raumatic	-	19a. Informant's Name/Relationship (Type	e, <i>Print)</i> 19b. I	Mailing Address (Street				Zip Code)
Ž	nd 2		Gloria J. Morris	Jaughter 465	10 Walnut	Court Lex	ington P	ark, MD 20	0653
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Medical Examinar must be notified at		20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other pla	ca)	Date 2	20c. Location - City o	r Town, State
9	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  3 ☐ Other (Specify)	movai irom State	eld-Echols	1	4-2004	Charlotte	Hall MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Spicense	M00052	22. Name and Addre		- The second second second second second second second second second second second second second second second		Home, P.A.
m	Departiment Department		Coward N. Brins	field, Jr.	22955 Holl				ryland 20650
Н	9.		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do no					Approximate Interval Between
	Physician		Immediate Cause (Final	47	2. 50	- Cand	1./	LAT de	Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequence of		(41200	044560	1 LAT Cle	Ten
	Examiner								
	A. Co	Je.	if any, leading to immediate	Due to (or as a consequence of	:				
	outed Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.						
o,	icate be executed physicien and s the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of	:				
68760,	ite be nysici	edicai	d.						
			IF FEMALE:						
Box	death certific e attending p d for use as 1	Physician/M	23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death	3 □Ectopic pregnanc	v		23d. Date of de	,
	0 0 0	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 9☐ Unknown	5 ☐ Other (specify) _	,		Month	Day Year
P.0	at the by the	Phy	9 Unknown						
	requires that the de een signed by the a nould be detached f	by	Part II. Other significant conditions cont	ributing to death but not resulting in t	he underlying cause giv	ven in Part I.			to the cause of death?
ord	w require been si should t	ted					1 U Ye	s 2 No 3 P	robably 4 Unknown
Records,	> 0 0	Completed					24a. Was ar autopsy	24b. Were a	utopsy findings available completion of cause of
<b>E</b>	The ate h page	Son					perform	ied? death? ☑No 1☐Ye	
ita/	sign: artific ctor,	Be (	25. Was case referred to medical examiner?			26. Place of Deat	(Check only one	9)	
<u></u>	hysic his co	ှင	Yes 2□No	ospital: 1 Inpatient 2 ER/Outp	atient 3 DOA	ner: 4 🗆 Nursing Ha	me 5 A Reside	nce 6 Other (Spe	ecify)
n o	ng P		27. Man er of Death  1 ★Natural 5 ☐ Pending	28a. Date of Injury 28b. Tir (Month, Day Year) Inj	ıry Wo	ry at rk?	28d. Describe hor	w injury occurred	
Division of Vital	Attending r death. Actor: After by the fune	Certification:	2 Accident investigation		M 1	Yes 2□No			
Ξ	r Att	Ě	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fame building, etc. (Specify)	n, street, factory, office		<ol> <li>Location (Str City or Town,</li> </ol>	eet and Number or F , State)	lural Route Number,
	ital c	S							
	To the Hospital or Attending Physicien: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only 2 Medical Examina	cian: To the best of my knowledge, ar: On the basis of examination and					
	the the	Med	29b. Signature and title of certifier	and manner stated.	29c. Licens	se number	29	d. Date signed (Mon	th Day Vasrl
	T W S		29b. Signature and title of certifier	toms	7				
			VION	Aurah	l)	12581		12-20	5-07
			30. Name and address of person who con			Decl I		Ma1	20650
1	Sta	oto.	William Boyd II, N 31. Date filed (Month, Day, Year)	32. Rigistrar's Signature	nt Lookout	road reo	iaidLown	, maryiano	20030
	Regist		DEC 3 0 20		grande				

		1 - State Registra MEND#23a(b/c)p  1. Decedent's Name (First, Middle, Later)		I,BMW,N	1 <sub>b</sub> CoCe	rtificate of	Death		Reg. No of Death		3. Time of Death
Physic /Medi		TILLIE	K MUT	Н				De e	cember	11 200	
Exami		4a. Facility Name (If not institution, give	e street and number)	-		4b. City, Town,	or Location o			c. County of Dea	
		Frederick Memori	al Hospit	al		Frede	rick			Frederi	ck
Funeral Director		5. Social Security Number 6. S  315-09-2377  Usual Residence of Decedent	ex 7. Ag ☐ M 2∏F	83	ast birthday) Yrs.	If Under 1 Yea Months Days		Min. (Mo	e of Birth nth, Day, Yea • 21,1	9. Bir 920 IN	thplace (State or Foreigr buntry)
aryland show	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
the M	Director	MD Frederic  10e. Street and Number	k			Thurmont	t				1 ☐ Yes 2 X No
with		506 Gateway Drive	W.			10f. Zip Code	217	788		Cilizen of Whal Co	
within 72 hours after death with the Maryland jiene. jiene Than "naturel", or Itams 23e or 28e-f show the Medical Examiner wat by multified at	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1  Yes 2 1			Was Decedent of f Yes, specify Cu		gin? (Specify Ye , Puerto Rican, e		14. Race · Ame Black, Whit	nican Indian, e, etc.
2 hours aturel', cal Ex	ted by	3X Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:		16a. Dece	dent's Usual Occi	pation		16b.	Specify: W	hite Industry
within 72 ene. than "na	Completed	(Specify only highest gra	de completed) College (1-4or 5	5+)	(Give life. i	kind of work done DO NOT use retir	e during most ed)	of working	132.		maastry
e filed wi Il Hygien othar th	Con	12			Publi	cations	_			IBM	
es 1 and 2 should be filed of the that and Mental Hygie of Health and Mental Hygie if item 27 is marked other rectmetic event, it	To Be	17. Father's Name (First, Middle, Last) Stanley Kwolek						r's Name <i>(First</i> , L <b>lia</b> Bur		,	
nd 2 sho alth and 1 27 ia ma r treume		19a. Informant's Name/Relationship (** Glenn D. Muth /*	Туре, Print) Son							or Town, State, 2 MD 2178	
ages 1 and of Height 12 to cotha		20a. Method of Disposition 1 ◯XBurial 2 □ Cremation 3 □		Ce	metery, crer	sition (Name of natory or other pla Memorial	ace)	Decembe	r	Location - City or	
permit. Pages 1 ar Department of Hea Important: If itam any injury or otha		'4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		Mac	22	. Name and Addr	ess of Facility	DeVol	Funer	al Home,	ch, Virgin: 10 East
402 % 0		23a. Part1. Enter the disease, or com	nlications that savens	l the death						, MD 208	7 / Approximate
Physician /Medical Examiner  bulyasician and bulian-Itausii sthe prijan-Itausii sthe p	I Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Renal Cue to (or as	Failur	ence of): e ence of).	(TYPES)					Onset and Death
that the death certificate E ed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 Fetal	death 3□	Ectopic pregnand Other (specify)	су			23d. Date of deli Month	very Day Year
w requires that been signed I should be det	by	Part II. Other significant conditions of	ontributing to death b	ut not resul	ling in the ur	nderlying cause g	ven in Part I.	236	Did tobacco	_	the cause of death?
The la ate has page 2	Completed								. Was an autopsy performed Yes 200 N	prior to death?	topsy findings available ompletion of cause of
Phyaiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	- V		O:	h	of Death Check			
ffer the	ation; To	1 Yes 2A No  27. Manner of leath 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Da)	ry 1	R/Outpatien b. Time of Injury	28c. Inju	4 LINUIS	28d. Des	Residence cribe how inju	6 □Other (Specury occurred	ufy)
of or Attandi after death. Diractor: A	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At hon c. (Specify)	ne, farm, stre	eet, factory, office		28f. Loca City	alion (Street a or Town, Stat	and Number or Ru te)	ral Route Number,
Hospitel 24 hours a Funaral I	edical C	29a. Certifier (Check only one)	ysician: To the best of the sais of and manner sta	examination	ledge, death on and/or inv	occurred at the trestigation, in my	ime, date and opinion, death	place, and due occurred at the	to the cause(s time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
24 24 FL etel	Ø.	OOL Circulated title of position				29c. Licen	se number		29d. D:	ate signed (Month	Day Yearl
To tha Hospitel or within 24 hours after To tha Funaral Dir. completely filled in h	Σ	29b. Signature and title of certifier								/	, Duy, rear,
To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Σ	296. Signature and title of certifier				Do	0604	117	12/	12/04	MS 21762

		1 - For State RegistraMFND#23aI+IIpc	MD12/20/04_FMW_			of Health and of Death		Reg. No.	004	4221
Physic	tian	Decedent's Name (First, Middle, La.	st)	- 200			2. Date of D	eath Day	Year	3. Time of Death
/Med				rthy			Decem	ber 11	2004	8:15 P.
Exam	iner	4a. Facility Name (If not institution, give	•			m, or Location of Dea	ath		inty of Death	
F		Sacred Heart Ho 5. Social Security Number 6. S		s. last birthday)	Hyatts If Under 1 Y		's. 8. Date of Bi	Pri	nce Geo	
Funera Director			☐ M 2 🖾 F	97 Yrs.		ays Hours Mi	1. (Month, D	$4, Y_{\Theta ar}$	9. Birthp	place (State or Forei
T		Usual Residence of Decedent					Jani	+,1507	wasi	nington,D
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any jury or other traumatic evant, If a Medical Evantral restrictiff at an once.	_	10a. State 10b. County		City, Town or Lo	cation				1	10d. Inside City Limi
8a-f	cto	Md. Prince	Georges H	lyattsvi	11e					1⊠Yes 2□N
0.2	Funeral Director	10e. Street and Number			10f. Zip Cod	de		10g. Citizen	of What Cour	ntry?
8 238	0	5801 Queens Cha			2	0782		Ţ	JSA	
er ue Itami	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent f Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No into Rican, etc.)	0- 14. [	Race - Americ Black, White,	can Indian, etc.
o .	by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1□Yes 2☒	No Specify:				nite
atura	ed	15. Decedent's Ed		16a Dece	dent's Usual Oc	cupation		16h Kind o	f Business/In	
a Paragraphic	Completed	(Specify only highest gra	de completed)	(Give	kind of work do	one during most of w tired)	orking		town U	
rtha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Libra						al School
otha vant,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle			
Aenta Aenta rked	TO E	Robert McCarthy				Mary J	Jane Cler	nents		
s ma		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	g Address (Str	eet and Number or F			wn, State, Zip	Code)
alth 27 i		Michael McCarthy,	C.F.X./Nephe	w 7513	Jacks	on AVe., ]	Takoma Pa	rk. Mc	1. 2091	2
真真人		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	1	Date		on - City or To	
ant: L	<b>'</b>	1 ☐ Surial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify				tery Dec.	16.04	Suit1	and, M	ſđ.
portr portr y Inju		21. Signature of Funeral Service Liven		22	. Name and Ad	Idress of Facility De	Vol Fune	ral Ho	ome	Iu.
89 5 9	1	1-lenny	tool	22	22 Wisc	consin Ave	. NW. Wa	sh. DC	20007	
hysician /Medical xaminer		23a. Part1. Enter the disease, or companion, shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	a. Cardiopulmo  Due to (or as a conse  b. Coronary A  Due to (or as a conse	onary F quence of): rtery D	ailure					Approximate Interval Between Onset and Death
hysician and the burial-transit	i Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hypertensic  Due to (or as a conse	quence of);						
physic s the b	edicai		d Hyperlipide	emia						
ind the useful certaincate be executed the by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregna Other (specify,				Date of delive Month	ry Day Year
igned t	by PI	Part II. Other significant conditions co		sulting in the ur	derlying cause	given in Part I.	23e. Did t	obacco use co	ontribute to th	e cause of death?
een sign		End Stage Alzheime	er's Disease				1 🗆 '	Yes 2□No	3 🗌 Proba	ably 4 🛣 Unknow
20 0	Completed	Stroke Carcinoma of Bread	st				24a. Was	an 24	o. Were autor	bsy findings available
	E o	Cancer of Breast						rmed?	prior to con death?	npletion of cause of
	0	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o	2X No	1 🗆 Yes	2 L No
is certific director,	To B	examiner? 1 ☐ Yes 2🏝 No	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outnation	3 DOA	Other: 4 Nursing I			What (Cassifu	.1
erthis neraldi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. lr	njury at Vork?	28d. Describe t	now injury occ	urred	)
r death. actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □ No				
within 24 hours after death.  To tha Funaral Diractor: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre	et, factory, offic	СӨ	28f. Location (S City or Tox	Street and Nui vn, State)	mber or Rural	Route Number,
within 24 hours at To tha Funaral D completely filled ii	edical	29a. Certifier (Check only one) 1 X Certifying Phyone) 2 Medical Exam	ysician: To the best of my knoiner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in m	time, date and place y opinion, death occ	e, and due to the curred at the time,	cause(s) and i date and place	manner as sta e, and due to	ated. the cause(s)
withi To 11 comp	M	29b. Signature and title of certifier				ense number		29d. Date sign	ned (Month, E	Day, Year)
1		MAN	MR)		D	51520		Dacomb	ar 1/	2004
	1 1	30. Name and address of person who c	completed cause of death (Iter	m 23a) (Type, f	rint)			Decembe	EI 14,	2004
			•		•					
		Bahram Pishdad,	M.D., 1328	8 Sout	hern 🗛	re. S.E. #	310 1/22	hingto	n n c	20032

			For State Registrar	State of Mai	ryland / Depa		lealth and N		ene 2004	42212		
F	hysicia		1. Decedent's Name (First, Middle, L	-				2. Date of Death Month	Day Year	3. Time of Death		
П	/Medic Examin	er	Theresa Frances  4a. Facility Name (If not institution, gr	ve street and number)			r Location of Death	December	4c. County of Death	h		
	uneral rector		213-38-1011	1 □ M 2/3(F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		ndel  place (State or Foreign  untry)  hington, DC		
Dallillo By Weight Department o	ls marke aumatic	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  Maryland Anne Arundel Fdgewater  10e. Street and Number  10f. Zip Code  10g. Citiz  3504 Cedar Drive  11. Marital Status  11. Marital Status  11. Marital Status  11. Mever Married 2 Married  11. Mever Married 2 Married  11. Marital Status  11. Mever Married 2 Married  12. Was Decedent Ever in U.S.  A Medecedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  11. Mever Married 2 Married  12. Was Decedent Ever in U.S.  A Medecedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  11. Mever Married 2 Married  12. Was Decedent Ever in U.S.  A Medecedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-  If Yes, Specify Cuban, M								or Town, State, Zip Code)  3711  Location - City or Town, State  Baltimore, MD  or Funeral Home, Inc		
death certificate be executed	ttending physicie	Physician/Medical Examiner	Sequentially list conditions, Tarry, Jacob of the mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	☐ Fetat death 3 ☐	Ectopic pregnancy			23d. Date of delive Month	very Day Year		
ding Physician: The law requires that the of h.	as been signe 2 should be d	ompleted by Physi	Part ii. Other significant continuous contributing to death but not resulting in the underlying cause given in Part i.									
	To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Certification; To Be C	25. Was case referred to medical examiner?  127 Yes 2 No Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury (Month, Day Year)  28. Place of Injury 2 Seb. Time of Injury 2 Nork?  28. Place of Injury 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28. Date of Injury 2 Seb. Time of Injury 3 Nork?  28. Place of Injury 4 Death Number or Rural City or Town, State)  29. Certifier (Check only one)  29. Signature and title of certifier  29. Signature and title of certifier  29. Signature and didress of person who completed cause of death (Item 23a) Type, Print)									
:	Stat Registra		31. Date filed (Month, Day, Year)  DEC 2 (	32. Restrar	s Signature	g the	egolis,	UND 3	1240/			

		1	For State Registrar		State o	f Marylan		artmen rtificate			and M		Reg. No.2	004	42	213
	Physicia		1. Decedent's Name ( Eunice									2. Date of De. Month DeC •	2Pay	2ỞỞ⁴4	3. Time o	P M
	/Medic Examin		4a. Facility Name (If n	Cres	apt				Al	ounty of Death legany						
	Funeral Director	*	5. Social Security Nun  553-28-  Usual Residence of D	6055	Sex I□M 2∏F	7. Age (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Apr.	18,1	920 C1	olace (State ntry) COSSN	or Foreign or NC
	aryland show	_	10a. State 1	Ob. County Allega	nv		ty, Town or Lo								10d. Inside C	City Limits
	the M	recto	10e. Street and Numb					10f. Zip	Code				10g. Citize	n of What Cou		X
	th with 23a or	alD	15200 W	linches	ter Ro	ad		2	150	2			USA			
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if item 27 is marked other than "natural", or Itema 23s or 28s-f show any figury or other traumatic event. Its Medical Evaniner must be rediffied all once.	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 XNo		Was Deced If Yes, spec 1 ☐ Yes		ispanic Ori in, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, pecify: W		
21215-0036	vithin 72 ho ne. han "naturi e Medical i	Completed	(Specify Elementary/Second	5. Decedent's E onfy highest gridary (0-12)	ducation ade completed) College (	1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	rk done d se retired	ation during mosi d)	t of work	ing		of Business/Ir	dustry	
	filed v Hygie other t	CO	1 2 17. Father's Name (Fi	irst, Middle, Lasi	")		Но	ısewi	те	18. Mothe	er's Name	(First, Middle,	Hom Maiden Si			
Maryland	should be and Mental markad c	To Be	John W									ldridg				
Mar	nd 2 shoulth and 27 is m		19a. Informant's Nam Melba Fl			hter						d. Cre				502
Jore,	Pages 1 ar		20a. Method of Dispo 1 XBurial 2 □	Cremation 3			Place of Disponentery, crea					31,04		ation - City or T		D
Baltimore	permit. Pa Departmen Important any injury		`4 ☐ Donation 5				22	2. Name an	d Addres	ss of Facilit	y H	afer F wy., I	uner	al Sei		PA
	Physician	83 14	23a. Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List only	one cause on	caused the dear	th. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory a	rrest,	3	Approxima Interval Be Onset and	tween
8760,	/Medical Examiner  hysician and  the burial-transit	Ilcal Examiner	Sequentially list concif any, leading to immacuse. Enter Underly Cause (Disease or in that initiated events resulting in death) La		c	(or as a consection as a conse		iba		atio	n.				HSd	langs
.O. Box 68	es that the death certifical gned by the attending phy be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	onths?	1 Live	itcome of pregn birth 2 Feta nant at time of a nown	aldeath 3	⊒Ectopic pr ⊒ Other (sp		·			23	d. Date of deliv	ery Day	Year
Ω.	requires that the een signed by th rould be detache		Part II. Other signific	ant conditions	contributing to c	leath but not re	sulting in the u	inderlying c	ause giv	en in Part I		23e. Did t	h./	contribute to		death?  Unknown
Vital Records,	The faw ate has b page 2 st	Completed	05 W	d to di-st						00 51		1 ☐ Yes	osy ormed? 20200	24b. Were autoprior to codeath?	opsy findings impletion of	available cause of
Vit	Phyaician: this certific ral director,	To Be	25. Was case referre examiner?		Hospital:	Inpatient 2	TER/Outpatie	nt 3 ☐ DC	Oth	0.00	of Deat ursing Ho	n <i>(Check only o</i> me 5 ∕esi		☐Other (Speci	fv)	
n of	<b>5</b> 0 0	on: T	27. Manner of Death	5 Pending		of Injury oth, Day Year)	28b. Time o	of 2	8c. Injur Wor	y at k?		28d. Describe			,,	
Division	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not determined	pe 28e. Plac	e of Injury - At h ling, etc. (Speci	nome, farm, st	reet, factory	===	Yes 2□	No	28f. Location ( City or To		Number or Rur	a <i>l Route Nur</i>	mber,
7	e Hospital 124 hours a Funaral letely filled	edical Ce	29a. Certifier 3 (Check only 2 one)	Certifying P	miner: On the I	e best of my kn basis of examination stated.	owledge, deal	th occurred ivestigation	at the tir , in my o	ne, date an pinion, dea	nd place, ath occur	and due to the ed at the time,	cause(s) a date and p	nd manner as : lace, and due !	stated. o the cause(	(s)
	To the within To the compl	Me	29b. Signature and ti	tle of certifier	nna.	· ^		290	A	e number				signed (Month,		
	Ve		30. Name and address	1 D -	completed cau	an of death (ltm	m 23a) (Type	, Print)		0591	- (-	h, Cu		00/20		7.6.
	Sta Regist		31. Date filed (Mohith	Day, Year)	2005	Registrar's Sign	ature	Societa	rug I	(a)	NU	( \//	n yen	K. WALL	( 100	L\76'L
	negist	-ai		OLLIA O O	2000	CAN THE PARTY OF T	,									

			For Stete Registrar	State of M	arylan	d / Depa	artment of I	Health and N Death		giene Reg. No.	04	42214
			Decedent's Name (First, Middle,	Last)					2. Date of De			3. Time of Death
	Physici		Norma M. Ni	chols					Month	20 Day	2004	1025 PM
	/Medic Examin		4a. Facility Name (If not institution,		)		4b. City, Town, o	or Location of Death			inty of Deeth	4221
		:	Mariner Her	11th of 1	Self	fir	Bel	Air		Н	acfo	rd
	Funeral		5. Social Security Number		ge (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bit	rth Year		place (State or Foreign
	Director		213-38-8794	1□M 2 <b>欠</b> F	90	Yrs.	Wortus Days	Hours Will.	9/8/49	7.4	Mary.	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	ocation					10d. Inside City Limits
	sho sho	5	MD Harf	ford		Aberde					Ι.	1 X Yes 2 No
	28a-1	Director	10e. Street and Number	.010			10f. Zip Code			10a Citizan	of What Cour	
	with a or		3502 Garrett	Ct			2100	1		itt y :		
	Jeath	era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.			ecify Yes or No	U.S.	Race - Americ	can Indian
10	rs after death with the Marylar I, or Items 23a or 28a-f show cominer must be notified at	Funeral	1 Never Married 2 Marrie	Armed Forces	?			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,	
036	eli, o	þ	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🖾 No	Specify:		Spe	ecity: Whi	te
21215-0036	72 hours "neturel", dical Exa	Completed	15. Decedent's	s Education		16a. Dece	dent's Usual Occup	pation during most of work	ring	16b. Kind o	f Business/Inc	dustry
2	d within 72 ho giene. Ir than "netu Ire Medical	ng u	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	nd)	arry			
21	ygier ygier ner th	Co	12	1 1		Tele	phone Ope				Telep	none
pu	be fill stat H d oth	Be	17. Father's Name (First, Middle, L					18. Mother's Nam			name)	
<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "neturel", or items 23a or 28a-f show eumatic event, the Medical Examinar must be notified at	7	Norman P. Hec			1			M. Pyle			
Maryland	12 st h and 7 is n treun		19a. Informant's Name/Relationsh Glenn R. Mauz				ng Address (Street Alton St	t and Number or Rur Aberr	deen, Ma			
<u>ئ</u> و	1 and Healt em 2		20a. Method of Disposition	·1	20b. P	lace of Dispo	osition (Name of		Date		on - City or To	
<u>jo</u>	ages int of t: If it		1 ⊠ Burial 2 □ Cremation			emetery, cre	matory or other pla ek Cemete	ce)				, Maryland
Baltimore,	nit. Partme		<ul> <li>4 □ Donation 5 □ Other (Sp</li> <li>21. Signature of Funeral Service L</li> </ul>									, rary rank
Ba	permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Importent: If item 27 is marked other thu any injury or other treumatic event, IDE 2008.		21. Signature of Funeral Service Licensee Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399									
			Approximate shock, or heart failure. List only one cause on each line.  Approximate shock, or heart failure. List only one cause on each line.									Interval 8etween
	Physician		Immediate Cause (Final disease or condition	u,	osep	515						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as								
		_	Sequentially list conditions,	b. — Dup to /or or	2 222222							
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c									
^	cate be executed physician and the burial-transit	xar	that initiated events c									
8760,	siciar buri	dical E										
289	fficate p physics as the	edic		d								
Вох	The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of delive	erv
<u>a</u>	death ne atte	icia	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a			⊒Ectopic pregnanc ☐ Other <i>(specify)</i>	у				Day Year
0	that the de ed by the detached	hys	9 Unknown	9□ Unknown								
Secords, P.O.	es tha igned be del	by P	Part II. Other significant condition	s contributing to death b	out not resi	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use c	ontribute to th	ne cause of death?
rg	w require been sig should b								1 🗆 '	Yes 2 No	3 ☐ Prob	ably 4 ⊟Unknown
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	e law requ has been je 2 shoul	plet							24a. Was	an 24	b. Were autor	psy findings available
JO R	The Tate has page	Completed							autor perfo	osy ormed? 25 No	death?	mpletion of cause of
Cho Vital	sicien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					26. Place of Death				
5 5	lis dir	To I	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatio	ent 2 🗆	ER/Outpatier	it 3□ DOA Oth	ner: 4 X Nursing Ho	me 5□Resi	dence 6 🗆 0	Other (Specify	y)
2:	ding Pt. After th		27. Manner of De th  1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time of Injury	28c. Injui Wor	ry at rk?	28d. Describe	how injury occ	curred	
Sio	Vttendi death. ctor: A y the fu	catl	2 Accident investigation in Accident in Accident investigation in Accident	ation				Yes 2 □ No				
MC( )	I or Atten after deatl Director: I in by the	Certification;	4 Homicide determin	28e. Place of In building, et	jury · At ho tc. <i>(Specif</i> y	me, farm, str /)	eet, factory, office		28f. Location (: City or Tox		mber or Rura.	l Route Number,
Orman Divis	Hospitel or Al 24 hours after of Funerel Directely filled in by		29a, Certifier 164 Certifying	Physics	-6 t	ula de la la la la la la la la la la la la la						
7_	4 th	edical	(Check only one)	Physician: To the best xeminer: On the basis o and manner st	if examinat	wledge, deati tion and/or in	n occurred at the til vestigation, in my o	me, date and place, ppinion, death occurr	and due to the red at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier	and manner st			29c. Licens	se number		29d. Date sig	ned (Month, I	Day, Year)
	- s - ō		· NA	MD			Day	1652		_		*
			30. Name and address of person w	tho completed cause of a	death (Item	23a) (Tvoe	Print)	1 4		UE (PM)	or a	LOUT
			Scott Hus	1.11/1 2	Marz	16 A	VINIAL	Bil Air	Ma	ry lan	d 2	1,2004
	Sta		31. Date filed (Month, DECar2	3 2004 <sup>32. Reg</sup>	ar's Signa	ture La				1		
	Registr	ar	%	- 200		J.	Gorales					

			1 - For &b State Registrar amended #4a	State of Maryland / Dep. perMD FCHD, tm12/204	artment of Health and	Mental Hygie	2004	42215	
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last,</i> Thomas Clint			2. Date of Death Month December	Day Year 17,2004	3. Time of Death 8:05 A M	
Exam	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	4c. County of Death Frederick			
	Funeral Director		5. Social Security Number 6. Sec 237–32–4419	7. Age (In yrs. last birthday) M 2 F 79 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.		9. Birth 925 Nort	nplace (State or Foreign Intry Carolina	
OUSO hours after death with the Maryland	Maryland e-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Frederic	10c. City, Town or Li				10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	3e or 28	al Director	10e. Street and Number 7130 Ira Sears Roa	ıd	10f. Zip Code 21710	Citizen of What Co	untry?		
	72 hours after death with the Marylan "natural", or Iteme 23e or 28e-f show Idical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1≦Yes 2□No. If Yes, Give WWII & Year or Dates:Korea	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2♥ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:		
'n	72 na na	Completed	15. Decedent's Edu (Specify only highest grad		edent's Usual Occupation a kind of work done during most of wo DO NOT use retired)	b. Kind of Business/Industry			
N	filed within Hygiene. other then " ent, the Mer.	Comp	Elementary/Secondary (0-12)	College (1-4or 5-)	Consultant	F'	Forestry Research		
⊆	d ta b	To Be	17. Father's Name (First, Middle, Last) Franklin Chalmers	Niblock		18. Mother's Name (First, Middle, Maiden Sumame)  Zeta Caldwell			
	and 2 should ealth and Men m 27 is marke her treumatic		19a. Informant's Name/Relationship (T) Ann Niblock (Wife)		ing Address (Street and Number or Ri Ira Sears Road,				
Baltimore,	of H of H if ite		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	Removal from State 20b. Place of Disposemetery, cre Smithsbur	osition (Name of matory or other place) rg Crematory 12/		Location - City or	Town, State Maryland	
Бапп	permit. Pag Department Importent: any injury c once.		21. Signature of Funeral Service Licens	R	Name and Address At Facility & OBERT E. DATLEY & 201 NORTH MARKET	SON FUNER	AL HOMES,	P.A.	
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury	a. Cardiac Arrest Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	eter the mode of dying, such as cardia			Approximate Interval Between Onset and Death Acute	
68760,	death certificate be executed e attending physician and ad for use as the burial-transit	cal	that initiated events resulting in death) Last						
C. Box	the death certific y the attending pl ched for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day		
ds, P.	uires that the de signed by the a d be detached t	by	Part II. Other significant conditions co	cco use contribute to the cause of death?					
Hecor	Physician: The law requires that the this certificate has been signed by th al director, page 2 should be detach	Completed	Axonal neur	opathy		24a. Was an autopsy performed	by prior to completion of cause of		
VIE	eician s certifi director	o Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death (Check only one)  3 □ DOA Other: 4 □ Nursing Home 5 Residence 6 □ Other (Specify)				
DIVISION OT VITAL MECOPUS, Lor Attending Physician: The law requires t	Attending Ir death.	Certification: T	27. Manner of Death  1  Natural 2  Accident 3  Suicide 4  Homicide	injury occurred  at and Number or Ru  State)					
ฉี	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	building, etc. (Specify)  rsician: To the best of my knowledge, dealiner: On the basis of examination and/or in		e, and due to the caus	e(s) and manner as		
	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number D46248	12/20/64			
O	*		30. Name and address of person who commartha Pierce, MD	ompleted cause of death (Item 23a) (Type 300 West 9th Stree	et, Frederick, Ma	ryland 217	01		
	Sta	ate	31. Date filed (Month, Day, Year) 2	2004 32. Registrar's Signature	South 1				

			For State Registrar	State of Maryland / D	Department of Head Certificate of De			ene 004	42216
			1. Decedent's Name (First, Middle, Last)	- 1.1			2. Date of Death		3. Time of Death
	Physici /Medio		Robert Wes	4 Ochterbed	C		Decomo	Day ZZ ZOO	4 5:13 PM
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Lo	cation of Death		4c. County of Dea	ith
		<b>.</b>	St. Marga	Hospital		Ltour .	MD	24. V	
	Funeral		5. Social Security Number 8. Sex	M 2□ F 67	Months Days	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) C	rthplace (State or Foreign country)
	Director		216-34-6366 Usual Residence of Decedent		113.		February 8	, 1937	Illinois
	yland		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Mar a-fsh	ctor	Maryland Saint Marys	Great	Mills				1 ☐ Yes 2 🙀 No
	th the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
	ath w 238		45900 Guenther Drive		20634			USA	
	er de	Funerai	The state of the s	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispa If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No	Specify:		Specify: W	h <b>i</b> te
Ö	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or tlems 23a or 28a-f show event, If a Medical Exert in ar must be redified at	ted	15. Decedent's Educ	ation 16a.	Decedent's Usual Occupation	on	1	6b. Kind of Busines:	
215	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done duri life. DO NOT use retired)	ing most of workii	ng		
2	ad wit	Con	8	•	erator/Owner		5	Sheet Metal	Fabricator
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		18	3. Mother's Name	(First, Middle, M	aiden Sumame)	
$\frac{2}{3}$	Men Men Marke Marke Marke	1º	Berthold Hoffman Och			Lucille			
Maryland 21215-0036	d 2 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Typ		. Mailing Address (Street and				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Item Medical Examinating the rediffical example.		Irmgard Lina Ochterbeck 20a. Method of Disposition	20b. Place of	5900 Guenther Dr: Disposition (Name of			ary Land 2063 Oc. Location - City o	
no	ages ent of it: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re '4 ☐ Dogation 5 ☐ Other (Specify)	amoval from State	y, crematory or other place)	Decem	nber		
altimore,	nit. Partme ortan injur		21. Signature of Funeral Service License		litan Crematory 22. Name and Address		2004 A1	lexandria, V	irginia
ä	permi Depar Impor any ir		Thichout Kury	tank	P.O. Box 270,	diner Fune Leonardtow	ral Home, n. Marvlán	P.A. nd 20650	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do re	not enter the mode of dying, s	such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Coop	1 noted and	) inco			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	of):	Joerse			
	Examiner		Sequentially list conditions, b						
	pe isi	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ot):				
•	xecut and	xan	that initiated events resulting in death) Last	Due to (or as a consequence	of):				
8760,	icate be executed physician and s the burial-transit	dicai E							
9	ifficate g phy as the	0 1							
Вох	eath certific attending p	M/u	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 Ectopic pregnancy			23d. Date of de	,
	deat	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death	5 Other (specify)			Month	Day Year
P.0	that the de ned by the a detached f	Physician/M	9 Unknown			- De et	One Didael		4 1 4 2
ŝ	9 50	by	Part II. Other significant conditions con	thouting to death but not resulting if	the underlying cause given i	in Part I.		s 2 No 3 F	to the cause of death?
Record	w require been si should	eted							-
3ec	has by	Completed					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
			Or Manager referred to another		_		1 ☐ Yes 2	□No 1 □ Ye	s 2 No
Vital		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1   Inpatient 2   ER/Ou	Other		(Check only one	nce 6 Other (Sp.	onitu)
0	F F E	<b>!</b>	27. Manner of Death	28a. Date of Injury 28b. 1	Time of 28c. Injury at		28d. Describe hov		scily)
0	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 19ai)	njury Work? M 1 ☐ Yes	s 2 🗆 No			
Division	or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	2	28f. Location (Stre City or Town,	et and Number or F State)	Bural Route Number,
	ital o	Cer				1			
	Hosp 24 hou Fune fely fil	edical	29a. Certifier   Certifying Phys	ician: To the best of my knowledge of On the basis of examination an	<ul> <li>death occurred at the time,</li> <li>d/or investigation, in my opini</li> </ul>	date and place, a ion, death occurre	and due to the car and at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b Signature and title operifier	Land manner stated.	29c. License n	umber	29	d. Date signed (Mon	th, Day, Year)
}	F 3 F ŏ		6 //	3440	Do	61522	1	-	23 2004
1	500		30. Name and ad re's of person who co	mpleted cause of death (Item 23a)	(Type, Print)	J. 23			-2 3
	110		^	500 Point Lookout R		, Maryland	20650		
	Sta	94	31. Date file (Month, Day, Year) DFC 2 7 2004	32. Registrar's Signature	Proof o	111			
1	Registi	200	DE U. G. ( / 11114	1 1 1 1 1	5.50 V. 3 A				

			. For	State of Marylar	nd / Depa	artment of H	lealth and M	lental Hygi	ienę	10017
			1 - State Registrar		Cei	rtificate of	Death	Re	ng. No. UU4	42211
	Physici /Medic		1. Decedent's Name (First, Middle, Last		bune	-1(		2. Date of Death Month Occur h	Day _ Year	3. Time of Death 915 A M
	Examin		4a. Facility Name (If not institution, give	^	17.00		r Location of Death		4c. County of Death	. 0
	Funeral		5. Social Security Number 6. Se	X Age (In yrs	. last birthday)	If Under 1 Year		8. Date of Birth	9. Birth	place (State or Foreign intry)
	Director		079-01-2165	□M 2ØF 97	Yrs.	Months Days	Hours Min.	(Month, Day, APRIL 16		ECTICUT
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Ba-fs	ctor	MARYLAND DORCHEST	ER C	AMBRID					1 X Yes 2 □ No
	with the	Funeral Director	10e. Street and Number 217 LINTHICUM DRIV	E		10f. Zip Code 21613	<b>.</b>	10	Og. Citizen of What Cou	intry?
	death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	U.S. 13.	Was Decedent of H	dispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-f show any injury or other traumatic event. It is Medical Examinat must be notified at ODGs.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕱 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	110411, 0(0.)	C===:6	ITE
50	"natur	etec	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work.	ina	16b. Kind of Business/I	ndustry
21215-0036	within jiene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	CLERICA	*		STATE OF CONNECTICU	T
nd	be filed tal Hyg d othe event,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Maryland	hould d Men marke matic	은	THOMAS G. BRENNAN  19a. Informant's Name/Relationship (7)	vne Print)	19h Mailir	on Address (Street	MARGARET		Y City or Town, State, Z	in Code)
Ma	nd 2 s alth an 27 Is I		MARGARET ANZALONE			-			, MARYLAND	
Baltimore,	of Head		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ F	1	Place of Dispo	sition (Name of matory or other plac	сө)	Date 2	20c. Location - City or 1	own, State
tim	it. Pag rtment rtant: njury o		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens	HU	NTT CRI				ALDORF, MA	
Ba	perm Depa Impo any i		Da P.Ku	R					VANS FUNER MARYLAND	AL HOME, 20715
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	one cause on each line.		4		or respiratory arre	st,	Approximate Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	aDue to (or as a conse	equence of):	na ~iti~				3 2445
	Examiner	L	Sequentially list conditions,			~ ti ~	)			
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence or).					
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
68760	cate by physic the bu	dicai	•	d						
Box 6	death certificat e attending phy id for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnance			23d. Date of delin	,
o.	0 0 0	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)	,		Month	Day Year
S, D	Se of	by	Part II. Other significant conditions co	intributing to death but not re	sulting in the u	nderlying cause giv		23e. Did tob	acco use contribute to	the cause of death?
Record	w requires been si should	ompieted	Deh. sc	not be				24a. Was an	24b. Were aut	opsy findings available
l Re		Comp						autopsy perform 1 Yes 2	ned? death?	ompletion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death			
of	this al dii	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	II 3 DOA	4   Nursing no	me 5 Resider 28d. Describe how	nce 6 □Other (Spec w injury occurred	ify)
sion	Attending or death.	atio	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □No			
Division	al or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, sti cify)	reet, factory, office		28f. Location (Str. City or Town,	reet and Number or Rui , State)	al Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai C		ysician: To the best of my kn iner: On the basis of examin and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of centrier			29c. Licens	700		d. Date signed (Month	•
)			17ms	An Int	12 mm		03701	3	December	17, 2004
			30. Name and address of person who of Bruce M. Co.	completed cause of death (Ite			a la Rya	A Pter	y Colombi	2100kg
	Sta Regist		31. Date filed (Month, Day, Year)	32. Resistrar's Sign		house			1	, ,

			For State Registrar			of Maryla		artment of I		and M		Reg. No.	104	422	218
	Physici	an	Decedent's Name		,	_					2. Date of De. Month	Day	Year	1 (120	of Death
	/Medic	al	Helen 4a. Facility Name (If		A.		owell	4b. City, Town, o	or Location o		Decen		28, 200 unty of Dea		O AM
	Examin	er	Memori	. 1 1 1	1	umberj		Cumbe		) dealin			lega	<b>M</b>	
4	Funeral		5. Social Security No	umber 6.	Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bird	th Yoar)	9. Bir	thplace (State	or Foreign
	Director		220-10-4	010	1 M 2 F	83	Yrs.	Months Days	Hours	Min.	8. Date of Bin (Month, Da Feb 12	, 1 <u>9</u> 21		W/V	
	and **	}	Usual Residence of 10a. State	Decedent 10b. County		10c. C	City, Town or Lo	ocation						10d. Inside	City Limits
	Manyli f sho	ō	WV	Minera	al		Ridge								es ≩□No
	r 28e	rec	10e. Street and Nun	mber				10f. Zip Code				10g. Citizen	of What C	ountry?	
	th with	Funeral Director	Rt. 1 Box	(106					26753			l	JSA		
	ems	iner	11. Marital Status		Armed F	cedent Ever in forces?	U.S. 13.	Was Decedent of H	Hispanic Original	gin? (Spe	cify Yes or No Rican, etc.)	- 14.	Race - Am-	erican Indian, te. etc.	
36	s afte	by Fu		ed 2 Married	1 ☐ Yes If Yes, G	2 □ No live <b>X</b>		1□Yes 2 No					ecify: wh		
215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show digal Examinar must be notified at	ed b	3√ Widowed	15. Decedent's I	Year or Education	Dates.	16a, Dece	dent's Usual Occup	pation				of Business		
215	nin 72 In "na Media	piet	(Speci Elementary/Second	ify only highest g	rade completed	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most	t of workir	ng			,	
21	filed within Hygiene. Ither than "	Completed		2	Conlege	(1 401 0 17)	Homer	naker				Own F	-		
	be file	Be	17. Father's Name (		it)						(First, Middle,		mame)		
Z a	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, I've My	10	George		(Time Drint)		10h Maili	an Address (Chron			Rice		Cén to	Zin Codel	
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heath and Mental Hygiene. ortent: if item 27 is marked other than "naturel; or items 23e or 28e-1 show injury or other treumatic event, the Medical Examiner must be notified at a.		Virginia C			aughter		ng Address (Street Box 401	and Numbe	er or mura	Ridge			/V <b>2</b> 67	53
	Heal Heal tem 2		20a. Method of Disp				Place of Dispo	osition (Name of matory or other pla	1001	D	ate		ion - City o	Town, State	
OE I	Pages ent of nt: If I	H		☐ Cremation 3 5 ☐ Other (Spec		State Fo		Cemetery	100)	_ 1	2/30/200	Fort	Ashby	١	ΛV
Baltimore,	permit. Pages 1 and 2. Department of Health ar Importent: If item 27 le any injury or other treu		21. Signature of Tu			Λ	2:	2. Name and Addre	ess of Facilit						
m	8 8 8 8		1/1	MM		DI	Ri	108 Viro	ii runei iinia Av	enue:	Cumber	land, M	D 2150	)2	
			23a Part 1. Enter the shock, or hea	ne disease, or co rt failure. List onl	mplications that y one cause on	caused the deleach line.	ath. Do not en	108 Vire	ng, such as	cardiac o	r respiratory a	rrest,		Approxim Interval B	etween
	Physician		disease or condition	(Final				nfarct						Onset an	1 S
	/Medical Examiner		resulting in death)	- (	Λ	(	equence of):							3.	
	ä	-E	Sequentially list con	nditions,	b. Coro	nary of	Arter	1 Dise	ase					unkn	OWN
	nsit	E I	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	rlying injury		,	,								
ć	execting and rial-tra	Examiner	resulting in death) i	Last	C. Due to	o (or as a conse	equence of):								
8760,	The law requires that the death certificate be executed tae been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai			d										
9	artifica ing ph e as ti	Med	IF FEMALE:											l	
Вох	ath ce	ian/	23b. Was decedent in the past 12		1 ☐ Live	utcome of preg birth 2 ☐ Fe	tal death 3	Ectopic pregnanc	ey .			23d	. Date of de Month	livery Day	Year
P.0.	that the death certific ed by the attending p detached for use as I	Physician/Med	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□ Unk	gnant at time of nown	death 5t	Other (specify) _	-						
	signed by d be deta	y Ph	Part II. Other signif	icant conditions	contributing to	death but not re	sulting in the t	inderlying cause gi	ven in Part I.		23e. Did t	obacco use	contribute t	o the cause o	f death?
rds	quires in sign	Completed by	Diabete	es Me	Mitus						10	Yes 201	lo 3□P	robably 4 [	Unknown
000	aw requir s been si 2 should	piet									24a. Was	an 2	4b. Were a	utopsy finding completion of	s available
R	The I	mo;									perfo	rmea?	death?	s 2□No	Cause of
ita	lcien: Th certificate rector, pag	Be (	25. Was case reference examiner?	red to medical						of Death	(Check only o				
of \	Physicien: this certific ral director,	P	1 □ Yes 2 🔼			/	ER/Outpatie	III JUDON	A. related		ne 5 Resid			ecify)	
Division of Vital Records,	fter fter	ion	27. Manner of Death	n 5 ☐ Pending investigati		e of Injury onth, Day Year)	28b. Time o Injury	Wo	nyat ork? ]Yes 2 ∐i		28d. Describe I	now injury of	curred		
/isi	l or Attending after death. Director: After I in by the funer	fical	2 Accident 3 Suicide	6 Could not determine	ho	ce of Injury - At	home, farm, st	reet, factory, office			28f. Location (	Street and N	lumber or A	ural Route Nu	ımber,
Ö	a after	Certification:	4  Homicide	33(3)(1111)	buil	ding, etc. (Spec	cify)				City or Tox	wn, State)			
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier (Check only					h occurred at the ti							e(s)
	the thin 2 the mplet	Medical	one) 29b. Signature and	title of pertifier	2 and ma	inner stated.		29c, Licens	se number			29d. Date si	igned (Mon	th, Day, Year)	
	F 2 5 8		)	/ Vm	sex ()	Jelle 1		TO	4127	5			-		
	70.0		30. Name and addr	ess of person wh	o contributed car	use of death (Its	em 23a) (Tvpe	Print)	SIC I	9	1000	Dece	inde	x 28	4004
	6		Dr Rob	1 .	Velik.	0	peton	Drive !	Suit	e 30°	8 Cu	nber	· lanc	1. MD	21502
	Sta		31. Date filed (Mon			Registrar's Sig		RA			,			-	
	Registi	rar	JF	AN U O ZI	105 66	die 1	" ASSOCIATION								

			1 - For State Registrar	State of M	arylan		artment of H			ntal Hygie	0001	42219		
	Physici		1. Decedent's Name (First, Middle, Last)  Edith F. Piltz							Date of Death Month ecember	Day Year 16, 2004	3. Time of Death  12:15 P <sup>M</sup>		
	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, or	Location of			4c. County of Death			
			Casey House				Rockvill				Montgome	ry		
	Funeral		5. Social Security Number 6. Sex	7. Ag M 2X F		(ast birthday)  Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, Ye		place (State or Foreign untry)		
	Director		Usual Residence of Decedent		8	9 113.			09	9/17/19	15 New	Jersey		
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits		
	B-1 st	ctor	MD Montgomery	У	Sil	ver Sp	ring					1 X Yes 2 □ No		
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g.	. Citizen of What Cor	untry?		
	s 23a	rai	8505 Springvale Roa	ad #118	Francia III	6 10	20910				U.S.A.	ing to dis-		
	iter de	Funeral Director	11. Marital Status  1 Never Married 2 Married	Armed Forces?		.5.	Was Decedent of Hi If Yes, specify Cuba	n, Mexicar	n, Puerto Rica	an, etc.)	14. Race - Amer Black, White			
036	ursal		3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify:			Specify: Wh:	ite		
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show drea Exstate matte natified at	Completed by	15. Decedent's Educ (Specify only highest grade	cation completed)		(Give	dent's Usual Occupa	durina mos	t of working	161	b. Kind of Business/I	ndustry		
2	nithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	Cleri	DO NOT use retired	)	3	c.	tate Gove	enmont		
2	Hygie Hygie ther ti nt, to	S	12 17. Father's Name (First, Middle, Last)	3		CTELL	Cai	18 Mothe	er's Name <i>(Fi</i>	irst, Middle, Mai		mient		
and	d be f antal l cad or	o Be	Joseph Miller						ia Venl		den damane)			
Maryland	shoul nd Me mark	T <sub>0</sub>	19a. Informant's Name/Relationship (Typ	oe, Print)		19b. Mailir	ng Address (Street a				ity or Town, State, Z	ip Code)		
ž	alth a 27 is		Rick Piltz, Son			4632	S. Chelse	a Lar	ne, Bet	thesda,	Maryland	20814		
altimore,	of He		20a. Method of Disposition  1 Burial 2 XCremation 3 Re	amoval from State	20b. F	Place of Dispo emetery, crer	sition (Name of matory or other plac	e)	Date	200	c. Location - City or 1	own, State		
Ĕ	Pag ment ant: h		'4 □ Donation 5 □ Other (Specify)	BITTOVAL ITOTA STATE	Ft.	Linco	1n Cremat	ory	12/20/	2004 B	rentwood,	Maryland		
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic evant, Ite M. After Exertine mail be notified an once.		22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland											
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that cause e cause on each li	the deat	h. Do not ent	er the mode of dying	g, such as	cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death		
	Priysician	Ø.	Immediate Cause (Final disease or condition resulting in death)	Metasta	tic	Gastri	c Cancer					Onset and Death		
	/Medical Examiner		Todaking in dodkin	Due to (or as	a conseq	uence of):								
		er	Sequentially list conditions, if any, leading to immediate	. Due to (or as	a conseq	uence of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	an an rial-tr		resulting in death) Last	Due to (or as	a conseq	uence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	d											
9	eath certific attending pl	/Mec	IF FEMALE:	3c. If yes, outcome	of progps	2501								
Вох	attend for us	ian/	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Feta	Ideath 3□	Ectopic pregnancy Other (specify)				23d. Date of deliver Month	very Day Year		
o.	the che	iysid	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9 Unknown	t time or a	eath J			-					
٥.		by Ph	Part II. Other significant conditions conf	tributing to death b	ut not res	ulting in the u	nderlying cause give	n in Part I.		23e. Did tobac	co use contribute to	the cause of death?		
rds	law requires as been sign 2 should be									1 🗆 Yes	2 X No 3 ☐ Pro	bably 4 Unknown		
000	aw re	piet								24a. Was an		opsy findings available		
ž	0 L 0	Completed								autopsy performed 1 ☐ Yes 2 🔯	d? death?	ompletion of cause of 2 No		
Vital Records,	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?							heck only one)				
of \	S S D	To	TE THE ZIX NO	ospital: 1 ☐ Inpatio		ER/Outpatier					e 6 NOther (Speci	My Hospice		
	ding F h. After funer	ion	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Work	rat ⟨? Yes 2 []		. Describe how i	injury occurred			
Division	l or Attending after death. Diractor: Aftel in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Ini	urv - At ho	ome, farm, str	eet, factory, office	.03 20	-	Location (Stree	t and Number or Rui	al Route Number.		
ō.	after after I Dira	Certification;	4  Homicide	building, et	c. (Specif	y)	7,			City or Town, S	itate)			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funaral Diractor: After thi completely filled in by the funeral.	Medicai C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best ter: On the basis o and manner st	f examina	wiedge, death tion and/or in	n occurred at the tim vestigation, in my op	ne, date an pinion, dea	d place, and th occurred a	due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)		
	To the within 2. To the L	Me	29b. Signature and title obsertition	1/1			29c. License	number		29d.	Date signed (Month,	Day, Year)		
			Elle H					413	218	- 1	2/16/0	)4		
	>		30. Name and address of person who cor						0_		1-0,0			
			Charles Harrison, N				ive #102,	Rock	cville.	, Maryla	and 20850			
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 2 0 200	32. Pegistr	ar's Signa	Ly S	Sports	1						

04-08430 Amend/Unpend Tenn/1, 23a, 27, perfile, 6840, 2/1/05 Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ROBERT PALLA WHM 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 29, **Physician** 2004 1:27 P ROBERT PALLIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 856 SNOW VALLEY LA GAMBRILLS ANNE ARUNDEL CO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months 1XM 2□F Hours Director 213-88-7114 FEB. 25, 1961 FRANCE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Exactiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL ODENTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a 856 SNOW VALLEY LANE 21113 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces:

1 X Yes 2 No
If Yes, Give
Year or Dates: UNKNOWN 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ģ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 is marked other the eny injury or other traumatic event, Ite. Once. 12 ENTREPRENEUR SALES AND EMBROIDERY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ALBERT **PALLIA** DORA SINGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ELIE ALBERT PALLIA/BROTHER 2820 DURMONT CT., ANNAPOLIS, MARYLAND 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>3</sup> 4 □ Donation 5 □ Other (Specify) LEBANON CEMETERY 01/02/2005 ADELPHI, MARYLAND EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1♥1Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner: 1∑ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Cother (Specify) SCENE 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending Injury 5 Pending 1 Natural after death. 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number E DECEMBER 30, 2004 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENN STREET, BALTIMORE, MARYLAND, 21201

State Registrar

31. Date filed (Month, Day, Year)

5.

MD Registrar's Signature

0 3 2005

			State of Maryland / Department of Head State of Maryland / Certificate of Department o		tal Hygien	200L	42221
	Physici /Medic		Decedent's Name (First, Middle, Last)     JOHN WILLIAM POOLE	N	Date of Death	ay Year 1/2004	3. Time of Death 2, 20 P. M.
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo FREDERIC	CK		c. County of Death	
	Funeral Director			Hours Min. J.A.	Pate of Birth Month, Day, Yea AN 24	9. Birthp. Cour	elace (State or Foreign htry) MD
	Maryland -f ehow iled ut	tor	10a. State 10b. County 10c. City, Town or Location 10c. MD FREDERICK FREDERICK			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28a	Funeral Director	10e. Street and Number 800 MOTTER AVE., #502 10f. Zip Code 21701		10g. C	itizen of What Cour	ntry?
980	be filed within 72 hours after death with the Maryland stal Hygiene.  dother than "natural", or Items 23a or 28e-f ehow event, I'm Medical Evair and instituted at	þ	11. Marrial Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 12 Yes 2 No 1956- 1 13. Was Decedent of Hisp if Yes, Specify Cyban, If Yes, Specify Cyban, If Yes, Sive Year or Dates: 1960	anic Origin? (Specify ) Mexican, Puerto Rican Specify:	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: WH	
21215-0036	within ene. than	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired)  CARTOGRAPHER	on ing most of working		Kind of Business/Ind	
Maryland	should be filed ind Mental Hygi marked other umatic event,	To Be (	17. Father's Name (First, Middle, Last) ROGER R. POOLE, SR.	8. Mother's Name (Firs		n Sumame)	
	nd 2 :		19a. Informant's Name/Relationship (Type, Print)  SANDY POOLE / NIECE  1191. Mailing Address (Street and 11912 HUNTER:	S LA., RC	CKVILÍ	E, MD	20852
Baltimore,	• · = =		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  MONOCACY CEMETE!			Location - City or To	
Balt	permit. Pag Department Important: eny injury o	i l	21. Signatur of Funeral Servide Licensee  22. Name and Address of HILTON FUI P.O. BOX	NERAL HOM	ME ESVILLE	, MD 2	0838
I	Physician /Medical Examiner	8 1	Due to (or + a consequence of):	Failure			Approximate Interval Between Onset and Death Day 5
8760,		cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Du to (or as a consequence of):  C. Due to (or as a consequence of):	lerotic C	<u>ʻand</u> ioVas	cular Us	ase years
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delive Month	ory Day Year
rds, P.	quires that in signed t uld be deti	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in the underlying	in Part I. 2	23e. Did tobacco 1 ☐ Yes	use contribute to th	ne cause of death? ably 4 Unknown
Il Records,	The law requir cate has been s page 2 should	Completed			24a. Was an autopsy performed? 1 Yes 2 XN	prior to con death?	psy findings available inpletion of cause of
Vital	yeicien: is certifica director, p	To Be	examiner?	6. Place of Death (Che 4 Nursing Home		6 ∏Other (Specifi	()
ion of	or Attending Physicien: ifter death. Director: After this certifica in by the funeral director, i		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Month, Day Year) Injury Work?		Describe how inj		,
Division	tel or Atte s after de sl Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street a	und Number or Aura te)	l Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	edicai	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated.	ion, death occurred at	the time, date ar	nd place, and due to	the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier  29c. License not be a control of the second of	7197	29d. D	ate signed (Month,	Day, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  15 W. 7th Sheet Frederick, MI	21701	Alan	Robre	er
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 2004  32. Registrar's Signature				

			_ 101	artment of Health and Mentificate of Death	ental Hygier Reg. I	211116 52222					
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death					
	Physicia /Medic		Margaret E. Rider		Dec.	15, 2004 11:15a <sup>M</sup>					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
			Oak Lodge Assisted Living	Pasadena  If Under 1 Year   If Under 24 Hrs.	9. Date of Birth	Anne Arundel					
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 DXF 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes Sep. 5,	ar) 9. Birthplace (State or Foreign Country) 1921 MD					
٠.	ס		Usual Residence of Decedent		ьср. 3,	1921					
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel; or Items 23e or 28e-1 show rematic event, the Medical Event retrinant be notified at	tor	10a. State 10b. County 10c. City, Town or L  MD Anne Arundel	ocation Pasadena		10d. Inside City Limits 1 ☐ Yes 2 🛣 No					
	with the 3e or 28e	i Director	10e. Street and Number 7753 Outing Avenue	10f. Zip Code 21122	10g.	Citizen of What Country? USA					
	ms 2:	Funerai		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	city Yes or No-	14. Race - American Indian,					
38	urs after al', or Ite	by	Amed Forces?  1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:	rican, etc.)	Black, White, etc.  Specify: White					
<u>ب</u>	72 ho	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin	16b	. Kind of Business/Industry					
121	within 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  Homemaker		Home					
р Б	filed v Hygie ther I		12 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid						
Maryland 21215-0036		To Be	Arden Fields, Sr.	Marie Da							
Mar	ind 2 shi alth and 127 is m ar treum			ing Address (Street and Number or Rural Chrisba Road, Seve							
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic av 2006.		1 A Burial 2   Cremation 3   Bemoval from State	osition (Name of matory or other place) cans Cemetery	20	Location - City or Town, State rownsville, MD					
Balt	permit. Departr Importa		21. Signature of Euneral Service Licensee	2. Name and Address of Facility arranco & Sons, P.? 95 Gov. Ritchie Hwy	A. Severn	a Park Funeral Home a Park, MD 21146					
	Prhysician JMedical Examiner whysician and price price and the price of the price o	i Examiner	23a. Part Enfer the disease, or complications that caused the death. Do not engaged to heart slipe. List only one ause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learns to mineral cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Quest and Death					
P.O. Box 68760,	death certificate e attending phys od for use as the	Physician/Medicai	1   Yes 2   No 9   Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year					
Ś	ires tha signed d be de	by	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 ☑ ★ ○ 3 □ Probably 4 □ Unknown					
of Vital Record	ysicien: The law requires that the is certificate has been signed by th director, page 2 should be detach	e Completed	25. Was case referred to medical		24a. Was an autopsy performed 1 Yes 2						
Division of Vita	1 Matural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 4 Homicide 6 Set Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  1 Matural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined building, etc. (Specify)  28. Place of Injury - At home, farm, street, factory, office City or Town, State)										
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or i and manner stated.								
)	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number  DL0094	29d.	Date signed (Month, Day, Year)					
			30. Name and address of person who completed calls of death (Item 23a) (Type Ell (att Gorbaty W)	aden lak Dru	+ Clon.	brue, ind, 2106/					
	Sta Registi		31. Ďate filed (Month, Day, Year)  DEC 2 0 2004	(male)	1						

			1 - For State Registrar	ate of Maryland		artment of l		and Mental H	ygiene Reg. No	~ U	04	42223		
0	Physici /Medic	an	Decedent's Name (First, Middle, Last)  R	uth Evelyn	Sto	nesifer		2. Date of Month	Da		Year	3. Time of Death 10:05 A M		
	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town,			40	. County	of Death			
	<b>A</b> .		Country Companions  5. Social Security Number 6. Sex	7, Age (In yrs. la	st birthday	Taneyto		24 Hrs. 8. Date of I		arro]		ounty  place (State or Foreign		
	Funeral Director		212-68-9015			Months Days		Min. (Month,	Day, Year,		Mary	ntry)		
	pu ,		Usual Residence of Decedent	100 000	Tour and			, 000.						
	show	<u>-</u>	10a. State 10b. County  Maryland Carroll Cou		Town or Lo						1	1 ☐ Yes 2 ☑ No		
	28a-1	Funeral Director	10e. Street and Number	urcy is	eymar	10f. Zip Code			10g. Ci	itizen of W	hat Cour			
	n with	Di	2000 Keysville Road	South		21757			Unit	ed S	tate	S		
	ems 2	ner	11. Marital Status 12. W	as Decedent Ever in U.S med Forces?		Was Decedent of	Hispanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)	No-		- Americ	ean Indian,		
36	be filed within 72 hours after death with the Maryland Hygiene. Hygiene do ther than "natural", or items 23e or 28e-f show event, the Martical Examiner must be notified a event.	by Fu		∬Yes 2. MNo Yes, Give par or Dates:	i	1□Yes 2X No		,			whi			
21215-0036	2 hour	led t	15. Decedent's Education		16a. Dece	dent's Usual Occu	petion		16b. F	Kind of Bus	siness/In	dustry		
215	within 72 ene. than "na the Media	Completed	(Specify only highest grade com Elementary/Secondary (0-12)	oleted) ollege (1-4or 5+)		kind of work done DO NOT use retire	during most ed)	of working				ŕ		
21	filed with Hygiene other than	Соп	8		ho	omemaker	1			n hom				
and		Be	17. Father's Name (First, Middle, Last)  Emory Ernest Valent	ine				r's Name <i>(First, Midd</i> Le Moser	ile, Maidei	1 Sumame	∍)			
Maryland	d 2 should be th and Menta 7 Is marked traumatic ev	2	*		19b. Maili	ng Address (Stree			nber, City	or Town, !	State, Zip	Code)		
	d 2		Charles L. Stonesia	fer / son										
ore,	Pages 1 and ment of Healti ant: If item 2 ury or other i		20a. Method of Disposition	COL	ce of Disponentery, cre	osition (Name of matory or other pla	ace)	Date Dec 29	20c. L	ocation - (	City or To	own, State		
ij	Pagiment		' 4 ☐ Donation 5 ☐ Other (Specify)	Keysville Union Cem. 2004 Keymar, Maryland										
Baltimore,	permit. Pag Department Important: any injury o		20b. Place of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Location - City or Town, State Keysville Union Cem. 22c. Name and Address of Facility Skiles Funeral Home 136 East Baltimore Street Taneytown, Md											
			shock, or heart failure. List only one cau	s that caused the death. se on each line.	Do not en	ter the mode of dy	ing, such as	cardiac or respiratory	arrest,			Approximate Interval Between Onset and Death		
	Pnysician /Medical	i	Immediate Cause (Final disease or condition resulting in death)	Cordea	e a	why	Mon	N						
	Examiner			Due to (or as a conseque	ence of):	afer	7 chi	0000						
	<b>4</b> 7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nge of):	The state of	1							
VI	ecuter and trans	Examine	that initiated events c.	Due to (or as a conseque	nnon of):									
60,	cate be executed bhysician and the burial-transit			out to (or as a conseque	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
687	ifficate g phys	ledicai	_ d											
XOX	eath certific attending p	an/N	230. Was decedent pregnant	yes, outcome of pregnand □Live birth 2 □ Fetal o		⊒Ectopic pregnanc	cy			23d. Date Mon		ery Day Year		
Records, P.O. Box 68760,	he dea the at	Physician/M		□Pregnant at time of dea □Unknown	ath 5[	Other (specify)				MOIT	I U I	Day real		
٥.	res that the de igned by the be detached	by Ph	Part II. Other significant conditions contribut	ng to death but not result	ling in the u	inderlying cause g	ven in Part I.	23e. Di	d tobacco	use contri	bute to th	ne cause of death?		
rds	v require: been sig should b	ed b	Demente	2	. 17	0		1 [	Yes 2	. No	3 🗌 Prob	pably 4 Unknown		
eco	e law requ has been je 2 shoul	Completed	'Crashour	fisher	ble	2 ding		24a. W	as an topsy	24b. W	ere auto	psy findings available mpletion of cause of		
		Соп						pe 1 🗆 Yes	rformed?	de	eath?	2 □ No		
Vital	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	al:		- 0:	bor	of Death (Check onl			7	assisted		
of	Phys or this oral dia	: To	1 185 2 X NO	a. Date of Injury 2	R/Outpatie 28b. Time c	f 28c. Inju	iry at	rsing Home 5 Re 28d. Describ		6 XOthe iry occurre		living facility		
ion	Attending ir death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		ork? ]Yes 2∐1	No			-	Lacifica		
Division	after de after de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	<ul> <li>Place of Injury - At horn building, etc. (Specify)</li> </ul>	ne, farm, st	reet, factory, office			(Street ar Fown, State		r or Aura	d Route Number,		
	To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Exeminer: Ca	To the best of my know in the basis of examination ad manner stated.	ledge, deat on and/or in	h occurred at the livestigation, in my	ime, date an opinion, deal	d place, and due to the hoccurred at the time	ne cause(s e, date an	and man	ner as st	tated. the cause(s)		
j	To th withir To th comp	Me	29b. Signature and Ittle of certifier	)		29c. Licen	se number		29d. Da	ite signed	(Month,	Day, Year)		
•			h	1	T	N	005	0/63	10	1/28	14			
	9		30. Name and address of person who complete Ernesto Mendoza, M.		-		West	minster,	Maryl	land	2115	7		
B	Sta Registi	- 4	31. Date filed (Month, Day, Year)	32. Segistrar's Signatu	k A	fauls).								

			For	State of Maryland	d / Depa		lealth and	Mental Hyg	ene 200	
	Physici	an	Registrar  1. Decedent's Name (First, Middle, Las		00	timeate or	Death	2. Date of Deat Month	Day Yea	3. Time of Death
	/Media	cal	John Leonard Andreas Andreas Andreas John Leonard Andreas Andr	nthony Santin	<u>i</u>	4h City Tayon o	r Location of Deat	December	26, 2004 4c. County of D	
	Examir	ner								-
	Funeval		41402 Richneck Co		ast birthday)	If Under 1 Year	icsville   If Under 24 Hrs	8. Date of Birth	St. Ma	Birthplace (State or Foreign Country)
	Funeral Director			<b>©</b> M 2□F 59	Yrs.	Months Days	Hours Min.	(Month, Day, Apr. 6,	1945 Pe	ennsylvania
Z alz	how		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
M	98-1	octo	Maryland St. Ma	ary's	<del></del>	1	<u>icsville</u>			1 Yes 2 No
t this	De D		10e. Street and Number			10f. Zip Code		11	g. Citizen of What	Country?
die	18 23 must	eral	41402 Richneck Co	ourt  12. Was Decedent Ever in U.	S 13	Was Decedent of H	20659	Specify Yes or No-	United 14 Bace: A	States merican Indian.
72 hours after death with the Marken	The alth and American Hygiene. Health and Mentral Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-f show other treumatic event, it is Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	o Rican, etc.)	Black, W Specify: V	hite, etc.
the string 23 bours at	"netur	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	eation during most of wo d)	rking	6b. Kind of Busine	ss/Industry
L L L	and Mental Hygiene. Is marked other than eumatic event, Ite M.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Sof	tware En	gineer		U.S. Go	vernment
	othe othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, A	faiden Sumame)	
of 2 should be file	Mental I arked o	10	Fernando Santii	ni			Mar	y Taroli		
6,6	and I s ms		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Maili	ng Address (Street	and Number or Ri	ural Route Number,	City or Town, State	e, Zip Code)
	Department of Health Importent: If item 27 Importent: If item 27 Importent: If our other truence.		Dolores Ann Sant				ck Court		csville,	
	or of H		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	1 0	emetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location - City	or Town, State
è	Department of the first state of		* 4 □ Donation 5 □ Other (Specify	St.					pper Darb	
	Departmer Importent any injury		21. Signature of Funeral Service Lines	See						Home, P.A.
	10 5 a a		Edward N. Brinsfie		052  22	955 Holl	ywood Roa	ad, Leona	rdtown, M	ID 20650-0279 Approximate
	hysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		todgu	in Lyn		correspiratory arre	, st,	Interval Between Onset and Death
Ε	xaminer		Sequentially list conditions,	b. Due to (or as a consequ						
To to	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	dence or).					
<b>5</b> 0,	sician and burial-transit	al Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
100	phys s the			, d						
אַסמ י	ed by the attending physical detached for use as the total detache	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	⊒Ect <i>o</i> pic pregnanc ⊒ Other (specify)	<u> </u>		23d. Date of Month	delivery Day Year
us, r.O.	signed by		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	ınderlying cause gıv	ren in Part I.		acco use contribute	e to the cause of death?  Probably 4 ØUnknown
or Vital Records,	has been signed should	Completed						24a. Was ar autops	y prior	autopsy findings available to completion of cause of
	ate h	lo S						perform 1 ☐ Yes 2	ed? death X No 1 □ Y	es 2X No
710	certificate rector, pag	Be	25. Was case referred to medical examiner?					ath (Check only on	9)	
	this ca	ပို	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐			4   Nursing F		nce 6 Other (S	pecify)
- S	After t	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe ho	w injury occurred	
מולים	death. ctor; A y the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	006 1	and the second and the second	7-17-11
DIVISION	if everyone the security of the securities of the securities in by the funeral director,	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, factory, office		City or Town	eet and Number or , State)	Rural Route Number,
- Toticson	within 24 hours after death.  To the Funerel Director, After this certificate ha	Medical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knorniner: On the basis of examinat and manner stated.	wledge, deal tion and/or in	th occurred at the till evestigation, in my o	me, date and place	e, and due to the caurred at the time, da	use(s) and manner ite and place, and c	as stated. due to the cause(s)
4	omple omple	Me	29b. Signature and title of certifier			29c. Licens	se number	25	d. Date signed (Mo	onth, Day, Year)
٢	->=0		1 Oslleb- mo			D 50	680		12/27	12004
1	9 D	1	30. Name and address of person who			Print)	EDHARD	10WN M	0 20650	
	St	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa		9				
	Regist	rar	DEC 2.7.21	004 100000	13 1	acts!				

DHMH 17 Rev 1/2001

			For State Registrar	State of Mai	ryland / Depa <i>Cei</i>	artment of F tificate of a	lealth and Me <i>Death</i>	ental Hygie Reg.		04 42	222			
,	Dharisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Y	'ear	of Death			
	Physici /Medio		PAUL ALTON SMOOT				I	DECEMBER	19, 20	04 2:4	45 P <sup>M</sup>			
	Examin		4a. Facility Name (If not institution, give st.	reet and number)		4b. City, Town, o	r Location of Death		4c. County of					
		,	ANNE ARUNDEL MEDIC			ANNAPOI If Under 1 Year		8. Date of Birth		ARUNDEL				
	Funeral Director		ONKNOWN	/ 2 F / Age	(In yrs. last birthday) Yrs.	Months Days	Hours Min	(Month, Day, Ye) DEC. 9, 2	ar) 004	9. Birthplace (State Country) MARYLAND	or r-oreign			
	yland how		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	cation				10d. Inside				
	e Ma	Director	MD QUEEN ANN	E'S	STEVENSV	<b>ILLE</b>				1 □ Ye	s 2 No			
	or 24	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of Wh	at Country?				
	a 23e	rai	115 UTAH ROAD	144 Dd1 F-		21666	Service Original (Service)	US		American Indian,				
326	within 72 hours after death with the Maryland lene. rthan "natural", or Itama 23a or 28a-f show the Macicel Examinational Lennollied at	by Funeral	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	2. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	1	fYes, specify Cuba I ☐ Yes 2 🕱 No	lispanic Origin? (Spec an, Mexican, Puerto R Specity:	ican, etc.)		White, etc.  WHITE				
215-0036	"natura	Completed	15. Decedent's Educa (Specify only highest grade		(Give	lent's Usual Occup kind of work done	during most of working	g 16b	. Kind of Busi	ness/industry				
7	filed within Hygiene. Ither than "	ошо	Elementary/Secondary (0-12)	College (1-4or 5+	INFAI		2)	I	NFANT					
D	e filed I Hyg othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Maid	den Sumame)					
a	should be ad Mental marked o	0 B	WALTER JAMES SMOOT	, II			CATHERINE	E AILEEN	TINSMA	N				
Maryland	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	g Address (Street	and Number or Rural	Route Number, Ci	ty or Town, St	ate, Zip Code)				
	an eath		WALTER J. SMOOT, I	I/FATHER			STEVENSVI		21666	-				
Hore			20a. Method of Disposition  1 ▼ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	moval from State	1	natory or other plac	Da FERY 12/22/			ILLE, MD				
Baltimore,	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service of risee	Lu hui	22 <b>F</b> F	Name and Addre	ss of Facility ELFENBEIN	& NEWNAM	FUNERA	L HOME,	P.A.			
К			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only die cause on each line.  Approximate Interval Between Onset and Death											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Necro-		Entero	colitis			Onset and				
	Examiner		Sequentially list conditions, b.	Extrer	ne Prer	naturi.	ty	The Table of Street	0130077	10	ł			
	P #	iner	ri any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of).		7							
	ficate be executed physicien and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
8/60,	be e)			500 10 (51 03 0	oorisoquorius ory.									
280		edicai	d.											
O. Box	at the death certifi by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date Month	,	Year			
ı	es that tigned by	y Ph	Part II. Other significant conditions cont	ributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobaco	co use contrib	ute to the cause of	death?			
rds S	quires n sign	ed by	Severe Intra	rentrici	Mar 14	emorrh	nage	1 🗆 Yes	2 No 3	Probably 4	]Unknown			
Vital Hecords,	aician: The law requires that the certificate has been signed by th irector, page 2 should be detache	Completed	Sepsis					24a. Was an autopsy performed	24b. We prid	ore autopsy finding or to completion of ath?  Yes 2 \( \subseteq \) No	s available cause of			
Ita		0	25. Was case referred to medical				26. Place of Death		NO IL	7163 2 140				
	> S P	To B	examiner? 1 ☐ Yes 2 No	spital: 1 Inpatient	2 ER/Outpatien	t 3□ DOA Oth	er: 4 🗆 Nursing Hom	e 5 🗆 Residence	e 6 □Other	(Specify)				
DIVISION OF	ge fe													
DIVIS	al or Attanding safter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office	28	Bf. Location (Street City or Town, St		or Rural Route Nu	mber,			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of er: On the basis of e and manner state	examination and/or in	n occurred at the tirvestigation, in my o	me, date and place, ar pinion, death occurred	nd due to the cause d at the time, date	e(s) and mann and place, an	er as stated. d due to the cause	(s)			
	To the within To the comp	M	29b. Signature and little of certifier			29c. Licens				Month, Day, Year)				
			カス・ル	10		104%	7158	De	cembe	r 19, 2	:004			
	144		30 ame d a ress of person who con	1		•	MIABOT TO	MD 03/2						
	LIF CH	to 4	31. Date filed (Month, Day, Year)	32. Registrar		J PKWY, A	NNAPOLIS,	MD 2140	1					
	Sta Registr			2004	que de	Smile								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Theodore Reed Swigert 17, December 2004 1:00 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner 3913 Isbell Street Silver Spring Montgomery If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 € M 2 🗆 F Yrs. June 13, 1921 Pennsylvania 199-05-8519 Director 83 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "netural", or items 23a or 28a-f show the Medical Evandings must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s any injury or other traumatic event, the Medical Examinar must Funeral 3913 Isbell Street 20906 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☑ Yes 2 □ No If Yes, Give 1942 – 46 Year or Dates: 1 ☐ Never Married 21 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ho Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Education 5+ High School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Fackler Theodore Wilson Swigert 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3913 Isbell Street, Delphine J. Swigert/Wife Silver Spring, Md 20906
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dec. 20 tz☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 2004 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland Cemetery Trancis de J. Collins Funeral Home Inc 21. Signature of Funeral Service License 500 University Blvd, W, Silver Spring, MD 20901 Ohn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or year failure. List only one cause on each line. Approximate Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Dehydration Examiner Due to (or as a consequence of): Examine Dementia-Severe 1998 been signed by the attending physician and should be detached for use as the burial-trensit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yea 2 TNo History of Urinary Tract Infection-2004 þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed History of Decubiti Ulcers-2004 History of Deep Vein Thrombosis-2004 1 ☐ Yes 2 ☐ No 1 Tes ޶ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 

S☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending tx□Natural 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident by the f efter death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours & To the Funeral E Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 071 lone D23788 www December 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Louise M. Stomierowski, MD 1396 Piccard Drive, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

parker

DHMH 16 Rav 6/95

Registrar

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2004

DEC

		For State Registrar		-	artment of F <i>rtificate of</i>			Reg. No	21111.	4222
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Physic /Medi		Donald H. Smi			T		Decemb		4, 2004	8:00 A
Exami	ner	4a. Facility Name (If not institution, give	street and number)			or Location of Deatl	1	4c.	. County of Death	
uneral		Holy Cross Hosp  5. Social Security Number 6. S	tal ex 7. Age	(In yrs. last birthday)	Silver If Under 1 Year	If Under 24 Hrs.		irth	ontgomer 9. B <u>i</u> rth	place (State or Fore
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Department of Health and Mentar Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28a-f show anjury or other yeumetic event. The Medical Examinational Demolities at once.	ō									1 X Yes 2 □
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SUL DE	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or N o Rican, etc.)	0-	14. Race - Ameri Black, White	
a a	by Fu	1 ☐ Never Married 2 💢 Married	1 ☐ Yes 2 🛣N If Yes, Give		1 ☐ Yes 2 X No				Specify	
al Ex	q pe	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual Occup	nation		16h K	Whi	
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othe vent.	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nar	ne (First, Middle	e, Maiden	Sumame)	
arkec etice	2	John H. Smith					ta A. M			
le m		R. Diane Smith/W	*	1.5	ng Address <i>(Street</i> D <b>enle</b> y Pl			-		p Code)
ther i		20a. Method of Disposition		20b. Place of Dispo	,	lace whea	Date		ocation - City or T	own State
	1	1 ☐ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other pla coln Cren	· I		1	ntwood,	
arime orteni injury		<ul> <li>4 □ Donation 5 □ Other (Specifical Service Licental Service</li></ul>			2. Name and Addre					TID
Impo any ir		Vant 1	Ve		1800 New					ıg, MD
		23a. Part1 Enter the disease, or com- chock, or heart failure. List only	plications that caused	the death. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between
ysician		Immediate Cause (Final disease or condition		Thrombos	is					Onset and Death
Nedical		resulting in death)	a	consequence of):						
aminer		Sequentially list conditions,	b	clerosis						
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andi use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		⊒Ectopic pregnanc				23d. Date of deliv	,
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g e	b	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the t	inderlying cause giv	/en in Paπ I.			Se contribute to	the cause of death bably 4 Xunkn
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ar this aral di	I	27. Manner of Death	28a. Date of Injur	28b. Time o	of 28c. Injur	ry at	28d. Describe		6 □Other (Speci ry occurred	ny)
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within 24 hours affer de <b>To the Funerel Directo</b> completely filled in by th	edical	(Check only 2 Medical Exam	ysician: To the best on niner: On the basis of	examination and/or in	th occurred at the ti	me, date and place opinion, death occu	e, and due to the urred at the time	cause(s	) and manner as : d place, and due !	stated. to the cause(s)
hin 24 the F	Medi	one)	and manger sta	ted.	29c. Licens				te signed (Month,	
		29b. Signature and title of certifier	7. /		0.	0 10 0 0				
7		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print) I awrea	) 1992			-17-0	
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		-	For State Registrer		,		rtificate					Reg. No	2006	42	229
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			Holy Cross Hosp  5. Social Security Number 6.		e (In yrs. la	st hirthday)	Silv If Under		Sprin		8. Date of Bir	th	ontgome	rthplace (State	or Foreign
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Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It will also a 21 is marked other than "natural", or itams 23a or 28a-f show other transmitter multiple and the modified at other transmitter modified at the modified	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usua kind of wor	k done d	during mos	t of worki	ng	16b. K	(ind of Busines	s/Industry	
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and	d be f	o Be	John S. Kline	2.,							et Matt		, , , , , , ,		
Z	Should Me Me mark	မှ	19a. Informant's Name/Relationship	(Type, Print)	- 1	19b. Maili	ng Address	(Street a					or Town, State,	Zip Code)	
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ore,	of Her	11 8	20a. Method of Disposition	Dames of from State	CO	nce of Dispo	matory or or	ther plac	(8)		ate	20c. L	ocation - City o	r Town, State	
Ĕ	Page nent ant: II		1 Surial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Special Control of Control		Gat	te of	Heave			200	ber 20 4	Silv	er Spri	ng. Mar	ryland
Baltimore,	permit. Pages 1 Department of H Important: If its any Injury or ot		21. Signature of Funeral Service Lic	ens		F'1	2. Name an	d Addres	ss of Facilit	ins	Funeral	l Ho	me Inc		
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Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	⊒Ectopic pr ⊒ Other (sp		′				Month	Day	Year
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۳,	es that igned b	by PI	Part II. Other significant conditions	s contributing to death t	out not resul	ting in the u	ınderlying c	ause giv	en in Part I		23e. Did	tobacco	use contribute	to the cause of	death?
rds	quire en sig suld b		Chronic Heart Fa	ilure,							1 🗆	Yes 2	□No 33€ F	Probably 4	Unknown
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Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Llassitali							(Check only				
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Division	or Attanding after death. Director: After din by the fune	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of In	jury - At hor	ne, farm, st	reet, factory	, office						Rural Route Nu	mber,
Ö	al or alter	Certification:	4  Homicide	building, e	tc. (Specify)						City or To	wn, Stati	Θ)		
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7	7.4			Oven	1		2							, 2004	
	UT		30. Name and address of person of Barry J. Levi		death (Item 0215 I			ad.	Bet	hesd:	a, MD 2	2081	7		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signati		,								
	Regist		DEC 20	2004 Den	مصماع	19	Set 1	Carlot 1	and a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2004 11:15 P. December 16, Virginia Mae Sconyers /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Montgomery Village Sunrise of Montgomery Village Montgomery viriage

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Oct. 13, 1 Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months 1 □ M 2 🗓 F Yrs. Director 91 1913 Washington, 578-10-3648 Usual Residence of Decedent the Maryland 10c. City. Town or Location injury pother traumatic event, the Mcdical Examiner must be notified at a. 10a State 10b County 10d, Inside City Limits 1 ☐ Yes 2X No Directo Maryland Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19310 Club House Road 20886 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify þ 3 ☐ Widowed 4 IX Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William D. Sullivan Mae Lindsav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 ia Barbara J. Demma/Daughter 18937 Lindenhouse Rd., Gaithersburg, MD. 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury goot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem. 12/21/2004 Silver Spring, MD. 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician ian/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Physic Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 4 Nursing Home 5 Residence 6 MOther (Specify) Livin 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 X Natural 1 TYes 2 TNo investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours at To the Funeral D 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8 December 17 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suhair Abulfarag, M.D., Suite 100, Rockville, MD. 20850

State Registrar

31. Date filed (Month, Day, Year) 20 2004 DEC

15215 Shady Grove Rd., 32. Registrar's Signature

			1 - For Stete Registrar	State of Maryla	•	artment of H rtificate of			giene Reg. No. 2004	42231
	Dhysisi	0.0	1. Decedent's Name (First, Middle, Las	t)		<u> </u>		2. Date of Dea Month	ath Day Yeer	3. Time of Death
	Physici /Medio		Nada	Scalettar	•	·		Decembe	er 13, 2004	5:32P M
	Examin	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of Deat	
			Holy Cross Hospi  5. Social Security Number 6. Se		rs. last birthday		Spring If Under 24 Hrs.	8 Date of Birt	Montgome	· · · · · · · · · · · · · · · · · · ·
	Funeral Director			ом 2DF 75	V	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan. 27	7, 1929 New	hplace (State or Foreign untry) Vork
			Usual Residence of Decedent					Jan. 27	, 1929 New	TOTA
	hrylan show	_	10a, State 10b, County	10c.	City, Town or L	ocation				10d. Inside City Limits
	8e-f.	Directo	Maryland Montgome	ery N.	Bethes					1 XYes 2 No
	with th	급	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
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40	fter d	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, White	
21215-0036	i within 72 hours after death with the Maryland liene. r than "natural", or Items 23a or 28e-f show Ite Medical Exercities must be notified at	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: Wh:	ite
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra-		(Give	dent's Usual Occup	during most of work	ing	16b. Kind of Business/	Industry
2	within lene. than	idm M	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		O II	
2			17. Father's Name (First, Middle, Last)	5+	Hom	emaker	18 Mother's Nam	e (First Middle	Own Home Maiden Sumame)	
Maryland	0 = 0 %	Be c	Leonidas Vodenlit	ch				Fritzhar		
<u>-</u>	should by and Menta marked	2	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street	and Number or Rur	al Route Numbe	er, City or Town, State, 2	Zip Code)
Š	nd 2 alth a 27 is		Dr. Raymond Scale	ttar-Husband	11921	Tildenw	ood Drive	, N. Bet	thesda, Md.	20852
Je,	item item		20a. Method of Disposition	20	b. Place of Dispe	osition (Name of matory or other pla	ce)	Date	20c. Location - City or	Town, State
Ē	Page nent ant: If ury o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	1 T	Parklawn	-Menorah	12/16	/2004	Rockville,	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumetic and other.		21. Signature of Funeral Service Licen	Stattlem	uez 1	70 Rocky	ille Piuk	e. Rocky	l Chapels, ville, Mary	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	eath. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	aPulmoi		ilure				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
	Examino.	<u>_</u>	Sequentially list conditions,	b. Due to (or as a con	t Cancer					
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate any firm thing. Cause (Disease or injury	230 10 (01 40 4 001)	30443.133 3172					
ć	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			. d						
9	ntifica ng ph	Physician/Medical	IF FEMALE:							
Вох	eath certific attending p for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	⊒Ectopic pregnanc	у		23d. Date of del	very Day Year
о. В	at the dea by the al	ysici	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5[	Other (specify)				<i>54</i> , 754.
<u>α</u> .	that the		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	uires sign	d by				, ,		1 🗆 Y	res 2. XNo 3. Pr	obably 4 Dunknown
COL	w requ	ete						24a. Was	an 24b. Were au	topsy findings available
Re	The lay	Completed							rmed? prior to death?	completion of cause of
Vital		0	25. Was case referred to medical				26. Place of Deat			2 X No
	8 is is	To B	examiner? 1 □XYes 2 □ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3∑ DOA Ott	her: 4 Nursing Ho	ome 5 Resid	lence 6 Other (Spec	cify)
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea.	r) 28b. Time of Injury	of 28c. Inju Wo	ry at rk?	28d. Describe h	now injury occurred	
Sio		cati	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2□No	22(1)		
Division	l or Attendater death Director:	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office		City or Tou	Street and Number or Ru vn, State)	iral Houte Number,
_	spital ours a leral I		29a. Certifier 1X Certifying Ph	ysicien: To the best of my	knowledge, dea	th occurred at the ti	me, date and place.	and due to the	cause(s) and manner as	stated.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical		niner: On the basis of exam and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier	,	- 10	29c, Licens			29d. Date signed (Monti	n, Day, Year)
)			Storley	a Scho	ent &	D1	.7368		Misley	
	20		30. Name and address of person who					0.6.5		
			Stanley A. Schwa			Park Dri	ve. Suite	200, S	ilver Sprin	g, MD 20902
	Sta Regist	ate rar	31. Date filed (Month, Day Year) DEC 20 20	32. Degistrar's S	girature 6	Sport				

			1 - For State Registrar	State of Ma		nd / Depai		Health and	d Mental Hy			42232
			1. Decedent's Name (First, Middle, L	Last)					2. Date of D	eath		3. Time of Death
	Physici /Medi		Gilbert O	scar Schlo	ottma	ın			Decemb	per 21	2004	6:30 A M
	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town	, or Location of D			ounty of Deat	
		.*	Harford Memori	al Hospital	L_	I:	lavre d	e Grace			Harfor	d
	Funeral Director		5. Social Security Number 6. 497–03–8025	Sex 7. Ag 1XIM 2□F	e (In yrs. 86	last birthday) Yrs.	If Under 1 Yes Months Day		lin. 8. Date of Bi (Month, D	rth av Year) 918	9. Birt	hplace (State or Foreign ountry) SOULI
	and		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Loca	tion					
	Aaryk F sho	5	MD Harf	ord								10d. Inside City Limits  1X☐ Yes 2☐ No
	n the Marylan r 28a-f show	Director	10e. Street and Number	oru —		berdeen	10f. Zip Code			10- 0''-		
	3a or	0	732 Webb Stree	t.			i i	1001		U.S	en of What Co	untry?
)	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13. W			(Specify Yes or Ni erto Rican, etc.)		Race - Ame	rican Indian.
A. A. A.	in K i 3-0030 within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Medical Examinational be indiffed at	þ	1 ☐ Never Married 2/□Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1XD₹es 2 ☐ 1 If Yes, Give Year or Dates¶	No		res, specify Cu ∃Yes 2[x]N		erto Rican, etc.)		Black, White	e, etc. ite
3, 31-04 8, 30 A	nin 72 hours in "natural" Wedical Ex	Completed	15. Decedent's (Specify only highest g	Education irade completed)		16a. Decede (Give ki	nt's Usual Occ nd of work don NOT use reti	upation e during most of red)	working	16b. Kind	of Business/I	ndustry
5	d with	E O	Elementary/Secondary (0-12)	College (1-4or 5	1+)		Servic			U.S.	Govern	ment.
~ (e	al Hy Toth	Be	17. Father's Name (First, Middle, Las	st)				18. Mother's h	lame (First, Middle			
\ <u>\$</u>	y can ould to Ment Ment arked	70	Charles Schlot	tman					Stumpf			
2	Vial 12 sh h and 7 is m raum		19a. Informant's Name/Relationship						Rural Route Numb			ïp Code)
7	T and 1 and Health		Mark Schlottma  20a. Method of Disposition	n (Son)	20b B	lace of Disposit	. Roya		Aberdeer			21001
18	portificate, Man yiding Zizio Demii. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nay injury or other traumatic event. Ith Mediangore.		Daurial 2 ☐ Cremation 3		St	emetery, crema Paul s	tory or other p	ran 12	Date /23/04		tion - City or 1	
2 =	artme artme ortani injury		<ul> <li>* 4 □ Donation 5 □ Other (Spec</li> <li>21. Signature of Funeral Service Lice</li> </ul>		00.				/23/04	ADELU	een, M	aryland —————
્ઉ હ	Dep de de de de de de de de de de de de de		Kusta A.	(MRICAL	10		arring	ress of Facility -Cargo Fi	uneral Ho	me, P	$o^{A}$ .	
ilbert	Physician /Medical Examiner  o and transitions of the physician of the phy	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as:  Due to (or as:  Due to (or as:  Due to (or as:	a consequence	n. Do not enter  where of:  uence of:	the mode of d					Approximate Interval Between Onset and Peath  2
nlothman G	death certificate be eattending physicia of for use as the bur	Physiclan/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at	2 🗌 Fetal	death 3□Ed	ctopic pregnan ther (specify)	зу		230	d. Date of delive	very Day Year
# 0	s that	by PI	Part II. Other significent conditions	contributing to death bu	it not resu	ulting in the unde	erlying cause g	iven in Part I.	23e. Did to	obacco use	contribute to 1	the cause of death?
0 2	equire en sig	edt	Mayer juston	t long					10	Yes 2□1	No 3 Pro	bably 4° Donknown
الحال	law re as be 2 sho	Completed	Prevenal	Asstenia					24a. Was		24b. Were auto	opsy findings available
	The ate h	E O							autor perfo	rmed?	prior to co death? 1 ☐ Yes	ompletion of cause of
, i	clan: ertific ctor,	Be	25. Was case referred to medical examiner?					26. Place of D	1 ☐ Yes eath (Check only o		TO Tes	2   NO
<i>-</i>	hysic this o	2	1 ☐ Yes 2 No	Hospital:		ER/Outpatient	3□ DOA O	L	Home 5 Resid		Other (Special	fy)
2	ling F	ion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		ry at ork?	28d. Describe h	ow injury o	ccurred	
	death death stor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not to	De Disas et lain	- A4 h			]Yes 2□No				
Division of Vital Records	tal or A s after al Direction by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	(Specify	me, tarm, street	, factory, office		28f. Location (S City or Tox	Street and N m, State)	lumber or Rura	al Route Number,
	To the Hospital or Attanding Physician: The law requires that the within 24 hours after death:  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	опе)	hysician: To the best o miner: On the basis of and manner stat		vledge, death or ion and/or inves	curred at the t tigation, in my	ime, date and pla opinion, death oc	ce, and due to the courred at the time,	cause(s) and date and pla	d manner as s ace, and due to	tated. o the cause(s)
	vit To con	2	29b. Signature and title of certifier	1/1	40	0. 0	29c. Licen	_			igned (Month,	
	11+1		Sancha Hi	(hoche	/1 <i>])</i> ,i	FACK Ph	D.	15004	.0	12-	-21-	2004
	4		30. Name and address of person who	completed cause of de	ath (Item	23a) (Type, Pri	nt)	1 1	D 210	40		
	Sta	.C	31. Date filed (Month, Day, Year)	32. Registra	Signat	ure .	dojene	00 , 1	200			
	Registra	ar :	DEC 2 1	2004	Willes.	13. 6	Deles					

			For	State of Marylan				d Mental Hy	giene	<b>7 9 </b>	
			1 - State Registrar		Ce	rtificate of	Death		Reg. No.	2004	12223
	Physici	an .	1. Decedent's Name (First, Middle, Last)	27. Smi4	4			2. Date of De Month	Day	Year	3. Time-of Death
	/Medic Examir		4a. Fecility Name (If not institution, give :			4b. City, Town, o	or Location of D	eath / Ø	4c. Co	ounty of Death	2003 M
	LXaiiiii	ici	Anne Arundel Med		r	Annan	olis			e Arur	nde1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		Annap If Under 1 Year Months Days		Min. (Month, Da	th y, Yea <i>r)</i>	9. Birthp Cour	place (State or Foreign ntry)
	Director		214-40-7857 Superior State   Usual Residence of Decedent	61	115.			<u>May 26</u>	194	3 Mary	yland
	yland how		10a. State 10b. County	10c. City	y, Town or Lo	ocation				1	10d. Inside City Limits
	Be-f s	ctor	Maryland Anne A	rundel Anı	napol						1 TYes 2 No
	with the	Funeral Director	10e. Street and Number			10f. Zip Code			-	n of What Cour	ntry?
	Jeath ns 23	eral	1450 Tyler Aven	12. Was Decedent Ever in U.	S. 13.	21403 Was Decedent of H	Hispanic Origin	? (Specify Yes or No		USA Race - Americ	can Indian,
ဖွ	or iter	Fur	1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		If Yes, specify Cub  1 ☐ Yes 2 ☐ No		uerto Rican, etc.)		Black, White,	
003	be filed within 72 hours after death with the Maryland nial Hygiene. ad other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							
-5	in 72 "nat	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working		of Business/In	
212	e filed within al Hygiene. I other than " vent, the Mes	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	T	echnici	an			te Hig instra	
nd	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle			
ryla	should be nd Menta marked matic ev	2	Jessie Smit		10h Maili	an Address /Street		ma Neal r Rural Route Numb	or City or T	Form Chair 7in	Codol
Maryland 21215-0036	nd 2 st Ith and 27 Is r		19a. Informant's Name/Relationship (Ty   Barbara Smith (N			•		ane Anna	-		•
	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 Is marked eny injury or other treumatic e once.		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	1	Date	-	tion - City or To	
Baltimore,	Page nent c ant: If ury or		1 Surial 2 Cremation 3 ☐ A Donation 5 ☐ Other (Specify)	lemoval from State Che	ews U meter	matory or other pla M Churc V	$\stackrel{h'}{=} \downarrow_{12}$	/20/04	Oven	sville	Md.
Salt	permit. Departr Importe eny inj		21. Signature of Funeral Service License	99	2	Name and Addre	ess of Facility				
	<u> </u>	$\vdash$	Jarry H. Aces 23a. Part 1. Enter the disease or comple	MCC483	Do not on	WM. Ree 821 Wes	t St.	Annapoli	uary s, M	d. 214	101 Approximate
	<b>5</b> 1		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		,			11631,		Interval Between Onset and Death
	Physician /Medical-		disease or condition resulting in death)	Due to (or as a consequ		ial I	ntar	ction			minutes
ı	Examiner		Sequentially list curiditions.								
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
	be executed ician and burial-transit	xan		Due to (or as a consequ	uence of):					-	
8760,	ate be executed oblysician and the burial-transit	ical		d							
9	ing ph	Medi	IF FEMALE:								
Вох	death certific e attending p id for use as 1	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	Ideath 3	Ectopic pregnanc Other (specify)	у		230	<ul> <li>Date of deliver</li> <li>Month</li> </ul>	ery Day Year
P.O.	at the de by the a tached	yslc	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	eaun o	_ Other (specify) _					
	requires that the een signed by th nould be detache	by Pi	Part II. Other significant conditions con	ntributing to death but not resi	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use	contribute to th	he cause of death?
ord	w require been sig should b		regentero	1 cm			-	_ 10'	Yes 2□!	No 3 Prob	pably 4 □Unknown
Records,	as b	Completed						24a. Was	osy	24b. Were auto prior to cor death?	psy findings available impletion of cause of
a	Th ate pag							1 ☐ Yes	rmed? 2 No	1 Yes	2000
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	fospital: 1  Inpatient 2	FB/Outpatie	nt 300A Oth	200	Death (Check only only only only only only only only		Other /Specif	(v)
υof		n; T	27. Manner of Death 1 → Metural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	The second secon	C-C-C-Selectory - C-C-C-Selectory	28d. Describe			
siol	Attending r death. sctor: After by the funer	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No				
Division	lor At after d Direct	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office		City or To		vumber or Rura	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t		29a. Certifier Certifying Phy	sician: To the best of my kno	wiedge, deat	h occurred at the ti	me, date and p	lace, and due to the	cause(s) ar	nd manner as si	tated.
	To the He within 24 To the Fu	ledical	one)	ner: On the basis of examina and manner stated.	tion and/or in			occurred at the time,			
ı.	To To	Σ	29b. Signature and title of certifier	in land		29c. Licens	se number	-0/	29d. Date s	signed (Month,	Day, Year)
,			30. Name and address of person who co	ompleted cause of death (from	33a) (Tuno	Print)	110	00	14	1007	r
			DR. MESSICS	180 Admi	Ral (	CochRA.	N DR.	86 Annapel	is M	14.214	0/
15	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	1 4					
	Regist	rar	DEC 2 0 2	UU4	St. A	10000					

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State Reg. No.  2004 422	31
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  Joan M. Sonner  2. Date of Death Month Day Year  Dec 31 2004 6:10P	
	Examin	er	4a. Facility Name (If not institution, give street and number)  81 E. Mechanic Street  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  14b. City, Town, or Location of Death  4c. County of Death  Allegany  15 Social Security Number  16 Sex  7. Age (In yrs. last birthday)  17 If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. Birtholace (State or Forest)	
	Funeral Director		212-38-7796 1 M 2 XF 70 Yrs. Months Days Hours Min. (Month, Day, Year) Country) Usual Residence of Decedent	gn
	e Maryian Ia-f show	ctor	10a. State10b. County10c. City, Town or Location10d. Inside City LimMarylandAlleganyFrostburg18 Yes 2 []	
	th with th 23a or 24 1st be no	al Dire	10e. Street and Number  81 E. Mechanic Street  10f. Zip Code  21532  USA	
980	ba filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or itams 23a or 28a-f show avant, the Madical Eracinal must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes, Sive Year or Dates: Specify: White	
21215-0036	within 72 ho ene. than "natur re Modical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  School Teacher  16b. Kind of Business/Industry  16b. Kind of Business/Industry  Education	
and 2	ould ba filed within Mental Hygiene. arkad othar than ' atic avant, Ire M.	Be	12 4 SCHOOL Teacher Education  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Alice E. Porter	
Maryland	and and sm	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  13507 Old Cresaptown Rd., Cumberland, MD	
Baltimore, I	Pages 1 and 2 lent of Health nt: If itam 27 iny or othar tra		20a. Method of Disposition  1 \( \mathbb{Z}\) Burial 2 \( \mathbb{D}\) Cremation 3 \( \mathbb{R}\) Removal from State (and the place) (by the place) (by the place) (by the place) (completely, crematory or other place) (completely, completely,	<u> </u>
Balti	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hafer Funeral Service, PA  1302. National Hwy. LaVale. MD 21502	
	Pnysician	2 /	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Batween Onset and Death disease or condition  a. Carcinoma of the Lung  Approximate Interval Batween Onset and Death 1 Yr	
	/Medical Examiner		Due to (or as a consequence of):  Diabetes  b.	
4	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. That Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  COPD  Due to (or as a consequence of):	
8760,	icate be executed physician and s the burial-transit	edical E	d. Hypothyroidism	
P.O. Box 6	death certif e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
ecords, P.	sign sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Esophogastro-Reflex/Depression  23e. Did tobacco use contribute to the cause of death?  1 Xres 2 No 3 Probably 4 Unknown	wn
Œ	The ate ha	Completed	24a. Was an autopsy findings availal autopsy performed? 1 \[ Yes 2 \] 1 \[ Yes 2 \] 1 \[ Yes 2 \] No	ole of
Vital	Physician: This certificate ral director, p	Be	25. Was case referred to medical examiner?  Hospital:   Hospital:   Check only one   Check	
of		on; To	27. Manger of Death 1 Pending 28a. Date of Injury (Month, Day Year) 27. Manger of Death 1 Pending 28b. Time of Injury Work? 28b. Time of Injury Work?	-
Division	r Atteniter deat	Certification;	2 Accident investigation 3 Suicide 4 Homicide   M 1 Yes 2 No   28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital of within 24 hours af To the Funeral Completely filled in	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within To the comp	M	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  D09157  Dec 31, 2004	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Paul Snow, 124 W. 3rd Street, Cumberland, MD 21502	
	Sta Registr		31. Date filed (Month, Day, Year)  AN 0 2005  32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 10:44AM Sharon -2004 Richards Stephen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Allegany Cumberland 1528 Shades Lane 8. Date of Birth (Month, Day, Jun 30, If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 6 Sex 9. Birthplace (State or Foreign 1 M 2 □ F **Funeral** Days Min Months Hours 1934 WB Yrs Director 218-30-0696 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show amy injury or other traumatic event, the Medical Examinat must be routilized at once. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Cumberland Yes 2 □ No Director MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 Completed by Funeral 1528 Shades Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No XYes, Give Year or Dates: Korea Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **PPG Industries** Factory Worker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Randolph Shaffer Sharon Robert Clifton Sharon, Sr. 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) MD 21502 11809 Aster Avenue SW Cumberland sis.-in-law Mariorie Sharon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/3/2005 MD Rocky Gap Veterans Cemetery Flintstone 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No for Day 4☐Pregnant at time of death 5 Other (specify) P.0. he 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2ETNo 2 No 1 Yes released Physicien: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 5 Residence 6 Other (Specify) 2 3☐ DOA Pis Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 1. Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 | Homicide within 24 hours a To the Funeral [ 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c License number D0054004 James 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avale Md Mationa

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State

Registrar

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31. Date filed (Month, Day, Year) JAN 0 6

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2005

221-E 32/Registrar's Signature Highway

			For State Registrar	State of N	-	epartment of Certificate of			g. No. UU4	42236			
	Physicia /Medic		Decedent's Name (First, Middle,     Mary	Ann	Tho	nas		2. Date of Death Month December		3. Time of Death 6:29am M			
	Examin	er	4a. Facility Name (If not institution, Frederick Memo	orial Hospi	tal	Fred	or Location of Dea lerick		4c. County of Death Frederic	k			
	Funeral Director		5. Social Security Number 220-03-0623 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 🖾 F	Age (In yrs. last birtho	Months Davs		, (Month, Day,	Year) 9. Birth Cou	place (State or Foreign ntry) 165566			
	e Maryland ta-f show tiffed at	ctor	10a. State 10b. County  Maryland Frederic	lck	10c. City, Town of					10d. Inside City Limits 1 ☐ Yes 2 X No			
e, Maryland 21215-0036	perriat. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "neturel; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director		12. Was Deceder Armed Forces and I make Force of I make Force	5? MNo 5: 16a. D (G (S 19b. N	1 ☐ Yes 2 No ecedent's Usual Occupive kind of work done fe. DO NOT use reting	ban, Mexican, Pue  Specify:  Inpation a during most of we  and  18. Mother's Na  Katheri  Stand Number or F	Specify Yes or Norto Rican, etc.)  orking  hame (First, Middle, Mane White  Bural Route Number,	14. Race - Ameri Black, White, Specify: Wh: 6b. Kind of Business/Ir nomemaker aiden Sumame)	can Indian, etc. ite industry			
Baltimore, N	permit. Pages 1 and Depirtment of Health Important: If item 27 any njury or other to		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Edward O. Thomas  7066 Up land Ridge Drive, Adamstown, MD 21710  20a. Method of Disposition 1   Burial 2 M Cremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Signifure of Funeral Service Licensee  22. Name and Address of Facility 22. Name and Address of Facility 32. Name and Address of Facility 33. Name and Address of Facility 34. Name and Address of Facility 35. Name and Address of Facility 36. Place of Disposition (Name of cemetery, crematory or other place) 36. Place of Disposition (Name of cemetery, crematory or other place) 37. Signifure of Funeral Service Licensee 38. Name and Address of Facility 36. Name and Address of Facility 37. Name and Address of Facility 38. Name and Address of Facility 39. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30. Date 20c. Location · City or Town, State 30c. Place of Disposition (Name of cemetery, crematory or other place) 39. Name and Address of Facility 39. Name and Address of Facility 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory or other place) 30c. Place of Disposition (Name of cemetery, crematory) 30c. Place of Disposition (Name of cemetery, crematory) 30c.										
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P.O. Box 687	death certific e attending p id for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of deliv Month	ery Day Year			
	The law requires that the to be a signed by the bas been signed by the bage 2 should be detache	þ	Part II. Other significant conditional Cardiomegaly, I	_	-				acco use contribute to t	the cause of death?			
I Records,		Completed	Gait Disorder, Types	Dementia -	mix_Vasc	ılar & Alz	heimer	24a. Was an autopsy performe	ed? prior to co	opsy findings available impletion of cause of 2 No			
Division of Vital	ling Physiclan: I. After this certific iuneral director,	Certification: To Be	25. Was case referred to medical examiner?  1  Yes	28a. Date of In (Month, L) ation of be 28e. Place of I		ne of 28c. Injury	then: 4 Nursing ury at ork? Yes 2 No	28d. Describe how	ice 6 Other (Special vinjury occurred				
	To the Hospitel or Attend within 24 hours after death To the Funerel Diractor; completely filled in by the I	Medical C	(Check only 2 Medical E	g Physicien: To the bes examiner: On the basis and manner	of examination and/	or investigation, in my	time, date and place opinion, death occurrence	curred at the time, dat	use(s) and manner as set and place, and due to d. Date signed (Month,	o the cause(s)			
)	To Wit	-	29b. Signalure and triefof certifier	en te	rilly	MD D5	4749		ecember 28				
	Sta Registr		and address of person of a Allen Reill 31. Date filed (Month, Day, Year)  JAN 0 6				,D-1, Fr	ederick, M	Maryland 21	701-6111			

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			1 - For State Registrar	State of Marylar	nd / Depar		lealth and		_	4 42237
	Physici /Medi Examir	al	1. Decedent's Name (First, Middle, Last  Timothy 4a. Facility Name (If not institution, give	Lee (	Wand		r Location of Deat	2. Date of Death Month Decombely	Day Ye	04 1:15 AM
No.	Funeral Director			Medica 17. Age (In yrs.		Balti If Under 1 Year Wonths Days	More If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Y Jan. 6,	(ear) 9. 1946 ]	Birthplace (State or Foreign Country) Pennsylvania
	the Maryland 28a-f show	Director	10a. State 10b. County  Delaware New Cast  10e. Street and Number	_	ty, Town or Loca Vewark				011	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23e or 28a-1 show any righty or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Dir	905 Waters Edge 1  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give		10f. Zip Code  19702  Is Decedent of Hes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	Black, W	States merican Indian, Thite, etc.
21215-0036	within 72 hoursine.	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed)  College (1-4or 5+)	(Give kir		ation during most of world)	rking 16	b. Kind of Busine	•
Maryland 2	ould be filed v Mental Hygie arked other t atic event, tt	To Be Co	17. Father's Name (First, Middle, Last) Ålfred Rudolph Wa	5+ aud	Teac	ner	18. Mother's Nam	ne (First, Middle, Ma y Lehr	Educati	Lon
	ss 1 and 2 shoot Health and item 27 is m		Dianne L. Waud/W.  20a. Method of Disposition	ife 20b. F		ters Ed	ge Drive	nal Route Number, C Newark Date Ember W	Delaware	e 19702 or Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 Burial 2 Commation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	R.A	A. Ferris	& Co. Inc	. 22,	2004 P	est Ches ennsylva A.	•
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S, O	w requires that I been signed by should be deta	ρ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the unde	erlying cause give	en in Part I.			to the cause of death?  Probably 4 Munknown
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Division of Vital	ding Phys h. After this funeral di	Certification; To Be	27. Manner of Death  1 Manual 5 Pending 2 Accident investigation	Hospital: 1 ⊠Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other	er: 4 ☐ Nursing H	th (Check only one) ome 5 Residence 28d. Describe how		pecify)
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	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical	(Check only 2 Medical Examinate)  29b. Signature and title of certifier	ner: On the basis of examina and manner stated.	tion and/or inves	29c. License	oinion, death occu number	rred at the time, date	and place, and d	nth, Day, Year)
7	10		30. Name and address of person who co	ompleted cause of death (Iten	n 23a) (Type, Pri	15 g	106	min, MD	2/18/0	4
- 4	Sta Registr		31. Date filed (Month, Day, Year)	32. Whiterar's Signa	H Che	de July	Dalfi	rum, 1/1)	21601	

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			Registrar		Cei	rtificate of De			J. No	
	Physici	an	Decedent's Name (First, Middle, Last,					<ol><li>Date of Death Month</li></ol>	Day Y	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Loc	cation of Death		4c. County of	Death
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	Funeral		5. Social Security Number 6. Sec	3.4 3.7 3/2	Yrs.		lours Min.	8. Date of Birth (Month, Day,	Year) 9	. Birthplace (State or Foreign Country)
	Director		212-36-3072 Usual Residence of Decedent	95				FEB.4,	1909   1	MARYLAND
	land		10a. State 10b. County	10c. Cit	ty, Town or Lo	ecation				10d. Inside City Limits
	Mary	ō	MARYLAND CHARL	ES W	ALDOR	F				1 ☐ Yes 2 🛣 No
	the 28a	rec	10e. Street and Number		· -	10f. Zip Code		10	g. Citizen of Wha	at Country?
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	be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Id other than "naturel", or Items 23a or 28a-f show event, It w Medical Examiner must be notified at	Funeral Director		12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Spec	cify Yes or No-		American Indian,
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Georgiann Baltimore, Maryland	ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (T)			ng Address (Street and				
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Ge	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 900g.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ F	Demoval from State	cemetery, crei	esition (Name of matory or other place)	<b>!</b>			ty or Town, State
<u>E</u>	Pag ment ant: ury c		' 4 ☐ Donation 5 ☐ Other (Specify)	METRO	POLIT	IAN CREMA	ATORY 1	2-28-0	4 ALEX	ANDRIA, VA
alt	Departiment Departiment Important Information Informat		21. Signature of Funeral Service Licens	● M00479	( / R	2. Name and Address of AYMOND FU	f Facility UNERAL	SERVIC	E, PA	
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			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the deal ne cause on each line.	th. Do not ent	er the mode of dying, s	uch as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death
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Ö	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	30201					
P.O.	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as tt	P.	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause given in	n Part I.	23e. Did toba	icco use contribi	ute to the cause of death?
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Ö	w req beer shou	lete						24a. Was an	24h We	re autopsy findings available
Be	iician: The lav certificate has rector, page 2	Completed						autopsy perform	prio dea	or to completion of cause of the the completion of the cause of the ca
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₹	sicia certi	o Be	examiner?	Hospital: 1 ✓Inpatient 2 □	] ER/Outpatie	Othor	<ol> <li>Place of Death</li> <li>Wursing Hom</li> </ol>			(Casaita)
of	Phy r this ral d	<del> </del>	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c, Injury at		8d. Describe how		(Ѕреспу)
on	ding th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work? M 1 ☐ Yes	2 □ No			
Division of Vital Records,	Atten dea ctor y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h		reet, factory, office	2			or Rural Route Number,
Ď	after after Dire	Certification:	4 Homicide determined	building, etc. (Speci	ify)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	sician: To the best of my know	owledge, deat	h occurred at the time,	date and place, a	nd due to the cau	ise(s) and mann	er as stated.
	ne Ho 1 24 1 1e Fu	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my opinio	on, death occurre	d at the time, dat	e and place, and	due to the cause(s)
	within 2 To the complet	M	29b. Signature and little of ce tiftier			29c. License nu	umber	290	d. Date signed (/	Month, Day, Year)
			> WILL	)		1)27	346	1	2/27/	04
			30. Name and address of person whe	ompleted cause of death (Ite	m 23a) (Type.	Print)			t	/
	13		Howard M. Haft	, MD, 12070	01d	Line Cent	ter. Wa	ldorf.	MD 206	502
	Sta	ate	31. Date filed (Month, Day, Year) JAN 0 6 21	32. Segistrar's Sign	ature	7.05		-		
	Regist	rar	JAN U D Z	NO Statues .	I A	A Charles				

O4-08034 Charles Winston

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	g Dhygiai	- W	1. Decedent's Name (First, Middle, Las					2. Date of Death		3. Time of Death
	Physici Medio/		Charle		ston				14, 200	
	Examin	er	4a. Facility Name (If not institution, give Easton Memorial H	ospital		Easton			4c. County of E	t
	uneral rector		5. Social Security Number 6. S  21654944  Usual Residence of Decedent	ex 7. Age (in yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Forei Country) aryland
/land	MO TE		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limit
with the Maryland	Items 23a or 28a-f show ner musi be notified at	Funeral Director	Md. Talbot			Easton	n	10	g. Citizen of Wha	1 ☐ Yes 2 ☐ N X
with	3a or	D	217 South Stre	et		100	601		-	S.A.
death	ms 2	nera	11. Marital Status	12. Was Decedent Ever in U.S.	. 13. y	Vas Decedent of H	fispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		American Indian,
1215-0036 within 72 hours after death ene.	ral', or ite Examine	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates:		Yes 2 Ne		o Rican, etc.)	Specify:	White, etc. Black
<b>5-0</b>	alse a	etec	15. Decedent's Ed (Specify only highest gra		16a. Deced	ent's Usual Occup kind of work done	pation during most of work	kin a 1	6b. Kind of Busine	ess/Industry
2127 d within giene.	od other than "n evant, the Medi	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life. [	carpen	during most of work d) ter		build	ing
Maryland 21215-0036 nd 2 should be filled within 72 hours aff	is markad other than aumatic evant, the M	To Be C	17. Father's Name (First, Middle, Last)  Malcom W					ne (First, Middle, M Florence		en
lary 2 sho and t	item 27 is marka othar traumatic	ľ	19a. Informant's Name/Relationship (		19b. Mailin	-	and Number or Rui			
9, <b>2</b> and and lealth	item 27 i r othar tre		Hosanna Wa	tkins /sister	as of Diago	4938 O	Id Trapp			Md. 21673
	= =		20a. Method of Disposition  1 □ Burial 2 □ Aremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	netery, cren	natory or other pla	ry 12/1		oc. Location - City  Dover	Delaware
Baltim permit. Pag Department	Important: I any injury o once.		21. Signature of Funeral Service Licer	hull	22	Name and Address 319	oss of Facility  Dover S	Dashiel St. East	ll Fune:	ral Servic
760, te be executed with the second s	sician and sician and sician and sician and sician stransit stree private transit	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any Isaan Is		ence of):	N. N. L.	al Inju	,	J.,	Approximate Interval Between Onset and Death
j 🖁	by the attending phy tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3	Ectopic pregnanc Other (specify)	y		23d. Date of Month	delivery Day Year
rdS, P	gned be de	þ	Part II. Other significant conditions of	ontributing to death but not result	ing in the ur	nderlying cause gr	ven in Part I.	23e. Did tob	V	te to the cause of death? Probably 4 Dunknow
	certificate has been si irector, page 2 should I	Completed						24a. Was ar autopsy perform Yes 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
VII	certif	Be	25. Was case referred to medical examiner?	Hospital:		t 3□ DOA Ott		th (Check only one		
on or ling Phy	After this uneral d	tlon: To	1 A Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Inju	y at	ome 5 Resider 28d. Describe how from recif	w injury occurred	Subject fell
the s	oire in b	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	1/	eet, factory, office		28f. Location (Str. City or Town, Euston, Mi)	State) 115 3.	r Rural Route Number, LCCLCS & ST
Hospital or 24 hours afte	To the Funeral I completely filled	edical	29a. Certifier 1 ← Certifying Ph (Check only one) 2 ← Medical Exar	ysician: To the best of my knowledger: On the basis of examination	ledge, death on and/or inv	occurred at the ti	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manne te and place, and	or as stated. due to the cause(s)
To the within 2	o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			d. Date signed (M	
₹ 3	<b>⊢</b> 8		Jan 18	all MAA			C.M.E.		cember 1	
			1) /	completed cause of death (Item 2		Print)	eet, Balt			
	Ci-	10	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	re		Dall	Jamore, P	ar y rand	<b>414</b> ∪1
	Sta Registr		DEC 1 6	2004	S. A.	foods.				

			, 101	epartment of Health and N Dertificate of Death	Mental Hygie	ZUHU 62260
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Media		Lloyd Ellsworth Wilson		Month DECEMBER	Pay Year 7:35 p <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			St. Mary's Hospital	Leonardtown		St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day, Ye	ar)  9. Birthplace (State or Foreign Country)
	Director		395-10-8236	rs.		, 1918 Wisconsin
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	l sho	ō				1 ☐ Yes 2 🕱 No
	28a-	Director	Maryland St. Mary's Leona	rdtown 10f. Zip Code	100	Citizen of What Country?
	with Sa or	ā	44380 Red Tail Hawk Lane	20650		U.S.A.
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S.		pecify Yes or No-	14. Race - American Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Evarither runal be notified at	by Funeral	1 ☐ Never Married XXMarried Armed Forces?  1 ☐ Never Married XXMarried If Yes Give	<ul> <li>13. Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerton 1 Test 2 No. Specify:</li> </ul>	Rican, etc.)	Black, White, etc.  Specify: White
21215-0036	72 hours "natural",	d be	3 Widowed 4 Divorced Year or Dates:	Consideration Liquid Convention	166	
5	be filed within 72 ha ital Hygiene. Id other then "netu event, Ital Me Jical	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	king	. Kind of Business/Industry
12	within than	mc	Elementary/Secondary (0-12)   College (1-4or 5+)	olice Officer		Police Department
d 2	Hygid Hygid Shr. I		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
an	d be ontal	o Be	Ellsworth Wilson	Laura		,
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It u Mi	<u>٢</u>		Mailing Address (Street and Number or Ru		tv or Town. State. Zip Code)
Ma	and 2 salth ar n 27 is		1 1 21 1			ltown, Maryland 2065(
ō,	- 7 5 5	3	20a Method of Disposition 20b. Place of	Disposition (Name of		Location - City or Town, State
JO L	0 0		XLX Burial 2 Uremation 3 Hemoval from State   /	d Vets. Cem. 1-4	-05 Che	eltenham, Maryland
Baltimore,	+ せせき		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Br		
B	Depa impo any ir		David A. Goff Com MO1095	22955 Hollywood RD	Leonard	town MD 20650
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate
	Pnysician		Immediate Cause (Final	atour E VID	1 1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as 1 cons size of 50)	any taxa	11 11-	Minnelled
п	Examiner		As I. Va	Myocardia	& Interes	less hour
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1. MA	720	14-51
	cuted nd ransif	Examin	Cause (Disease or injury that initiated events	rasa Hren	Detec	457
oʻ	an ar	EX	resulting in death) Last Due to (or as a consequence or	): ( ) /		7,-
8760,	cate be executed physician and the burial-transit	dicai	d			<u> </u>
θ	nd pri	Med	IF FEMALE:			
Вох	death certifii e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
	0 0	sic	1  Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		North Day Year
P.0	that the de led by the a detached t	Phy	Part II. Other significant conditions contributing to death but not resulting in	the underhing eques quen in Rest I	22a Did tehaar	to use contribute to the cause of death?
S,	res the signed I be de	by	Part II. Other significant conditions contributing to death but not resulting in	me underlying cause given in Fart I.		2 No 3 Probably 4 Unknown
Records,	The law requires that the the law sequires that the bas been signed by the bage 2 should be detache	Completed			-	2 THO SET TODADLY 4 CONTRIBUTION
lec	has b	npie			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
F		Co			performed 1 ☐ Yes 2 <b>2</b>	
Vital	Physician: this certificatal director, participate in the control of the control	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	th (Check only one)	
of	± 100	To:	1 ☐ Yes 2 ☐ No	atient 3 DOA 4 Nursing H	ome 5 Residence	6 □Other (Specify)
n		lon	1 Natural 5 Pending (Month, Day Year) In	me of 28c. Injury at work?  M 1 ☐ Yes 2 ☐ No	20d. Describe flow if	ilary occurred
<u> S</u>	teat feat tor: the	Ical	2 Accident investigation 3 Suicide 6 Could not be determined to the determined and the country of the country o		28f Location (Street	and Number or Rural Route Number,
Division	after Direction by	Certification;	4 Homicide determined building, etc. (Specify)	ii, sireet, ractory, office	City or Town, Si	
	To the Hospital or At within 24 hours after or To the Funeral Direct Completely filled in by		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place,	and due to the cause	e(s) and manner as stated.
	Me Fu	edical	(Check only one)  2   Medical Examiner: On the pasis of examination and and manner stated	or investigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and little of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	Q.L.		b Jamat LOUVE A	D 06419	1	12-28-04
•	4		30. Name and address of person who completed cause of death (Item 23a) (1	ype, Print)		14. 10 0
	, /		DR. JAMES JARBOE PO BOX 640 HOL			
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist	rar	I / DEC 2 9 200 M	Roselle &		

LLOYD ELLSWORTH WILSON

			For	State of Ma	ryland / Dep	artment of F		•	iene o o	10011	
		·	For Stete Registrar		Ce	rtificate of	Death	,	eg. No UU4	42241	
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day Year	3. Time of Death	
6.	/Medic	al	Agnes Cecelia V 4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	Dec.	27, 2004 4c. County of Death	4:45 AM	
	LXdiiii	ICI	Bayside Nursing				gton Park		St. Mary's		
	Funeral		5. Social Security Number 6. S	9x 7. Age □ M 2 <b>K</b> F	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		place (State or Foreign intry)	
	Director		218-24-3573 Usual Residence of Decedent		82			May 22,	1922 Mary	land	
	show	<u>_</u>	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 X No	
	28a-f	Director	Maryland St. Ma	ary's	Mechani	csville 10f. Zip Code			Og. Citizen of What Cou		
	3a or		28485 Flora Con	ner Road		20659	)		U.S.A.	,	
	ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H		pecify Yes or No- c Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.	
36	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married  3XXWidowed 4 ☐ Divorced	1 ☐ Yes 2 <b>XX</b> N If Yes, Give Year or Dates:	0	1 ☐ Yes XXNo	Specify:		Specify: B1a	als	
21215-0036	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show deal Ever, if set must ke modified at		15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occup	nation	kina	16b. Kind of Business/l		
121	iene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done DO NOT use retired	d)	All I	0 71		
d 2	filled v Hygie other t		12   17. Father's Name (First, Middle, Last)		Hom	emaker	18. Mother's Nam	ne (First, Middle,	Own Home Maiden Sumame)		
/an	Aental rked c	To Be	Thomas Edward Ha	arris			Katie	Catherin	e Garner		
Maryland	2 should be and Mental Is marked (		19a. Informant's Name/Relationship (						r, City or Town, State, Z		
	iges 1 and 2 should be filled within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "naturel; or Items 23a or 28a-f show or other traumatic event, the Madical Ever in at most ke notified at		Mary Dodson Holt  20a. Method of Disposition	/ Daughter	20b. Place of Disp	osition (Name of	C = 1 - 2 - 2 - 2		nicsville, 20c. Location - City or T		
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot		XX Burial 2 Cremation 3 C 4 Donation 5 Other (Specifi			matory or other place. Mem. Gard	ı		Leonardtown		
alti	Departm Departm Importar any inju		21. Signature of Funeral S	-					Funeral Ho	ome, P.A.	
	89 E 29		Edward N. Brinsfi		M00052 2	2955 Holl	Lywood Ro	ad Leona	rdtown, MD	20650	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each lin	θ.	2	1 3		5	Approximate Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	a we to (or as a	a consequent of):	Lower	hote	presn	ence		
В	Examiner		Sequentially list conditions,	b				n 			
	ted nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a cous∋quence of∫.						
Ċ,	ate be executed hysician and the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a	a consequence of):						
8760,	ate be physicia the bur	lical		d							
89 X	death certifica e attending phy d for use as th	an/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of delis	(80)	
Box	death e atten	iclan	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 200	1□Live birth 4□Pregnant at	2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	y		Month	Day Year	
P.0	that the de ad by the detached	Physici	9 Unknown	9∐ Unknown				00 - Did t-	<u> </u>	the course of death?	
ds,	es mg	by	Part II. Other significant conditions of	ontributing to death bu	er not resulting in the i	ingeriying cause giv	ren in Part I.		bacco use contribute to es 2□No 3□Pro		
Record	> 17 %	ompleted	Atast Lloul	Valor.	Congesti	V Hear	& Failur	24a. Was a		opsy findings available	
	The tay ate has page 2	omb	Amention	And	the Mil	Ulas		autops perfor		ompletion of cause of	
Vital	Physicien: this certificated ral director, I	BeC	25. Was case referred to medical examiner?	Hospital:	746	7		th (Check only or	10)		
of		To	1 Yes 2 Yes	1 L Inpatie			4X Avursing r		ence 6 Other (Spec	ify)	
ion	Attending Phraden and the death.  sctor: After this by the funeral of	ation	1 → Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		rk?  Yes 2 □ No				
Division	- 0	ertification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, s c. (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,	
	Hospitel (24 hours a: Funerel Dittel) filled i	O	29a, Certifier	vsician: To the best of	of my knowledge, dea	th occurred at the ti	me, date and place	and due to the c	ause(s) and manner as	stated.	
	To the Hospitel of within 24 hours af To the Funerel D completely filled it	Medical	(Check only 2 Medical Exar	niner: On the basis of and manner sta	examination and/or it	nvestigation, in my o	pinion, death occu	rred at the time, o	late and place, and due	to the cause(s)	
	To the To the Complet	×	29b. Signature and title of certifier	1		29c. Licens		2	29d. Date signed (Month	Day, Year)	
,	The same		ON NAME OF THE OWNER OWNER OF THE OWNER OWN		eath (Ita- 00-1 CT	D/9	1911		14/39/0	7	
	' W			.D., 23415	, , , , , ,	•	Californ	nia, Marv	land 20619		
	Sta		31. Date filed (Month, Day, Year)		s Signature						
	Regist	rar	UEUZ	J /UU4 / /	MARCHE, PR	Bosch	6				

State of Maryland / Department of Health and Mental Hygien 42242 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** December 8:37 PM M 27 2004 James Michael Wathen /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 42474 Clover Hill Road Hollywood Mary's Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□F 49 Director Dec. 11, 212-66-7307 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No Directo Ho11ywood Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Pages 1 and 2 should be filed within 72 hours after death with 0 Items 23a 42474 Clover Hill Road 20636 IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ö If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Boiler Plant Mechanic Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Dorothy E. Abell 2 Joseph Charles Wathen, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 is eny injury or other trau once. Rhonda Wathen/Wife 42474 Clover Hill Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place)

Charles Memorial

Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition December 30, 1 ■ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 2004 Leonardtown, Maryland 21. Signature of Funeral Secice Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270 Leonardtown, Maryland 20650 Tridence e, or complications that caused the d List only one cause on each line 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Yletastat Immediate Cause (Final Adenocarunoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 5 Other (specify) 4 Pregnant at time of death be detached P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 2 No 1 Yes or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation illed in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 4035 Notch TATRIUC CROSS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DEC 28

2004

		1- State of Maryland / Department of Certificate of Registrar		Reg.	2004 4774
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Deat
Physicia		Martha Jean Weimer			Day Year r 28, 2004 8:30 AM
/Medic Examin			n, or Location of Death	December	4c. County of Death
<b>E</b> xamin	-	21807 Potomac View Drive Leon	ardtown,		St. Mary's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	
Director		296-03-2687 1 Months Day		May 14,	
>		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location			
shov	_				10d. Inside City Lin
<u>.</u>	Director	Maryland St. Mary's Leonardtown			1 Tyes 2 X
or 2	Dire	10e. Street and Number 10f. Zip Cod	e	10g.	Citizen of What Country?
3 23e		21807 Potomac View Drive 2065			U.S.A.
jiene. rrthen "neturel", or Items 23e or 28e-f show the Medical Evantiner must be notified at	Funeral	Armed Forces? If Yes, specify C	of Hispanic Origin? (Spe Cuban, Mexican, Puerto f	cify Yes or No- Rican, etc.)	<ol> <li>14. Race - American Indian, Black, White, etc.</li> </ol>
io iii	by F	1 ☐ Never Married XXMarried 1 ☐ Yes 2XNo If Yes, Give 1 ☐ Yes 2XNO If Yes, Give 1 ☐ Yes 2XNO If Yes, To Dates:	No Specify:		Specify:
lure E				1 101	White
	Completed	15. Decedent's Education 16a. Decedent's Usual Oc. (Give kind of work do life. DO NOT use rel	ne during most of working	19	o. Kind of Business/Industry
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al Hygiene. other then vent, It e Me	e Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First Middle Main	Own Home
ntal ed o	0				
and Menta Is marked reumalic ev	2	Charles C. Sailer  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stre		Frieda :	Steele ity or Town, State, Zip Code)
7 Is I					
of Health and Mental Hyg item 27 Is marked othe other treumalic event,		Gene S. Weimer / Husband 21807 Potom.  20a. Method of Disposition   20b. Place of Disposition   (Name of	ac View Dri		cdtown, Maryland 2
Department of H Importent: If ite any injury or ot once.		1 ☐ Burial	place)	200	,
rtmer		'4 □Donation 5 □Other (Specify) Brinsfield-Eche			narlotte Hall, MD
Depa Impo any ir		21. Signature of Funeral Service Coansee 22. Name and Ad	DI		Funeral Home, P.A
					ltown, Maryland 20
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of c shock, or heart failure. List only one cause on each line.	dying, such as cardiac of	r respiratory arrest,	Interval Between
nysician		Immediate Cause (Final disease or condition Breast (annuls)	metas	Justro.	Onset and Death
Medical xaminer		resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, b.			
. <del></del>	iner	if any, leading to immediate cause. Enter Underlying			
physician and the burial-transit	Examin	Cause (Disease or injury that initiated events c.			
cian a		Due to (or as a consequence of):			
the b	dlcal	d			
ing p e as	Φ -	IF FEMALE:			
ale has been signed by the attending oage 2 should be detached for use as	an/	23b. Was decedent pregnant in the past 12 roonths?	ncy		23d. Date of delivery  Month Day Year
he a	<u>S</u>	1   Yes 2 No 9   Unknown 5   Other (specify)	)		Month Day rear
ed by the attending detached for use as	Physician/M				
igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		co use contribute to the cause of death?
been si should	Completed			1 \( \text{Yes}	2 No 3 Probably 4 □Unkno
2 5	ple			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause
page	E O			performed	death?
certificate rector, pag	O	25. Was case referred to medical	26. Place of Death	1	
h. After this certific funeral director,	To B	examiner? 1 ☐ Yes 📆 No	Other: 4 \(\sum \) Nursing Hom	ne 5 X esidence	e 6 Other (Specify)
er th				8d. Describe how in	
ath. r: Af	atlo	TACTION S TOTAL	☐Yes 2☐No		
	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ce 2	8f. Location (Street City or Town, St	t and Number or Rural Route Number,
ecto by th	ert	building, etc. (apecity)		City of Town, St	1419/
s after death.	13 1	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the	e time, date and place, a	nd due to the cause	e(s) and manner as stated.
hours after de inerel Directo y filled in by th			v oninion death occurre	d at the time, date	and place, and due to the cause(s)
n 24 hours after de ne Funerel Directo netely filled in by th		(Check only deficed Exeminer: On the basis of examination and/or investigation, in m and manner stated.	y opinion, death occurre		
within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical C	(Check only one)    Variable   Medicel Exeminer: On the basis of examination and/or investigation, in m and manner stated.    29b. Signature and title of certifier   29c. Lice	ense number	29d.	Date signed (Month, Day, Year)
within 24 hours after death. To the Funerel Director: A completely filled in by the fu		(Check only one)    Variable   Medicel Exeminer: On the basis of examination and/or investigation, in m and manner stated.    29b. Signature and title of certifier   29c. Lice		29d.	
within 24 hou To the Funer completely fill		29b. Signature and title of certifier  29c. Lice	ense number	29d.	Date signed (Month, Day, Year)
within 24 hou To the Funer completely fill		(Check only one)    Variable   Medicel Exeminer: On the basis of examination and/or investigation, in m and manner stated.    29b. Signature and title of certifier   29c. Lice	ense number 00 56 7 5 1	29d.	Date signed (Month, Day, Year) (2)28/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Reg.	NG-UU4 42244
Physic /Med		Decedent's Name (First, Middle, Last)     SIM YUET	WONG			Day Year 3. Time of Death 5 30 AM
Exam	iner	4a. Fecility Name (If not institution, give str HEBREW HOME OF GREA		4b. City, Town, or Location of Deat		4c. County of Death MONTGOMERY
Funera Directo		5/8./4.3803	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month Day Ye	ar) 9. Birthplace (State or Foreign Country) 1912 CHINA
Maryland f show	jo	Usual Residence of Decedent  10a. State 10b. County  MARKE AND MONTECOMER	10c. City, Town or Lo			10d. Inside City Limits 1 □ Yes 2 ☑ No
with the ?	I Direct	MARYLAND MONTGOMER 10e. Street and Number 13313 Foxhall Drive		10f. Zip Code 20906		Citizen of What Country?
patitimiore, interpretation ATATIO-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other treumetic event, the Medical Examinar must be notified at onne.	by Funera	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	Mas Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc.  Specify: ASIAN
d within 72 hours all giene. er then "netural", or the Wedical Exam	ompleted	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)  8 th	Completed) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) WASHER	rking	. Kind of Business/Industry
d be filed antal Hyg ced other c event,	o Be C	17. Father's Name (First, Middle, Last)  (UNOBTAINABLE)	WONG		ne (First, Middle, Maid	den Sumame) LEE
nd 2 should be file th and Mental Hy 27 is marked oth rreumetic event	F	19a. Informant's Name/Relationship (Types MAY LEE / GRANDDAUGH	o, Print) 19b. Mailin	ng Address (Street and Number or Ru		
Definition of your permit. Pages 1 an Department of Heal mportent: If item 2 any injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponental from State		Date 20c	Location - City or Town, State  ITLAND, MARYLAND
permit. I Departm Importer any inju		21. Signature of Funeral Service Licensee	0 22	2. Name and Address of Facility H	INES-RINAL	DI FUNERAL HOME, INC ver Spring, MD 20904
Physician be executed by sician and buriat-transit strib buriat-transit	Į.	23a. Part 1. Enter the disease, or complice shock, or hear failers. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Lister Underlying Cause (Disease or injury that initiated events resulting in death) Last	W	of Cordio in		Interval Between Onset and Death
death certi e attending d for use a	Physiclan/Me			□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
• E 29	þ	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 No 3 Probably 4 Onknown
The The ate has page	Completed				24a. Was an autopsy performed	
Physicien: The riscontinuous tribicate oral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Ho:	spital: 1   Inpatient 2   ER/Outpatier	Othor	ath <i>(Check only one)</i> Iome 5□ Residence	6 □Other (Specify)
ding P. After	Certification:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in 28f. Location (Street City or Town, St	and Number or Rural Route Number,
Hospite 4 hours Funerel ely fillec	Medical Ce	29a. Certifier (Check only one)  29a. Certifier  1 Certifying Physic 2 Medical Examine one)	cian: To the best of my knowledge, deat r: On the basis of examination and/or in and manner stated	h occurred at the time, date and place vestigation, in my opinion, death occu	o, and due to the cause arred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the I within 2 To the I complet	Med	Jansul /	Muser stated.	29c. License number		Date signed (Month, Day, Year)
		30. Name and address of person who com  () () 5 Mon  31. Date filed (Month, Day, Year)	trose road	Print) CONSULT	Month	CC 13, 2004 R MD 20852
S Reais	tate trar	DFC 2.0 2004	32. Registrar's Signature	Souls		

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** DECEMBER 13, 2004 2:00 A M DOUGLAS JAMES WHITTIER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEARTLAND HEALTH CARE CENTER ADELPHI PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 1 € M 2 □ F MAY 29, 1958 Director 554-08-3087 46 CALIFORNIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itams 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No MARYLAND PRINCE GEORGES RIVERDALE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6004 RHODE ISLAND AVE. 20737 U.S.A. filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12TH PRINTER SIGN COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental P Be ARNOLD KENNETH WHITTER JANICE MARIE Pages 1 and 2 should nent of Health and Men HUBACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAUDIA RANKIN / AUNT 2879 E. CLAIRTON DR. HIGHLANDS RANCH, CO 80126 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pag Department Important: It any injury o FT. LINCOLN CREMATORY 12-17-2004 BRENTWOOD, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fundal Service Ligense 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20704 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hermonya week /Medical Due to (or as a consequence of) Examiner + Immobility mpaired if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Wound to Heard in 1988 The law requires that the death certificate be executed physician and s the burial-transit unshot Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. signed det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? shasta, Muscle 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Whasan autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide hours after within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely fi Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 29c. License number 12/14/04 U31001

State Registrar 31. Date filed (Month, Day, Year) 20 2004 DEC

32. Registrar's Signature

8

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kewit

oaks

Greenbelt,

7500 G-eenway Conta Dr. #430

Box 68760.

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			1_ For	State of	Maryland	/ Depa	artment	t of H	ealth a		ntal Hyg	giene	0001	10	01.0
			Registrar  1. Decedent's Name (First, Middle	2 / act)		Ce	rtificate	e or L	Jeatn		. Date of Dea	leg. No	2004	42	246
п	Physici	an	Francis Willia								Month	Day	Year	3. Time o	
	/Medi		4a. Facility Name (If not institution				4h City	Town or	Location o		ecembe		2004 County of Deat		P M
	Examir	ıęr	Frederick Memo	-			Frede		Location	Death			cederic		
	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. las		If Under	1 Year	If Under 2	24 Hrs. 8	Date of Birth				or Foreign
	Director		214-36-0824 Usual Residence of Decedent	<b>1</b> M 2□ F	65	Yrs.	Months	Days	Hours	Min. M	ar. 21	, 19	9. Bird Co Mar	yland	
	yland how		10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside C	City Limits
	e Ma 3a-f s	cto	Maryland Frede	rick	Thi	urmon	t							1 ☐ Yes	2 □ No
	within 72 hours after death with the Maryland ene. than "natural; or Itams 23e or 28e-f show re Madical Examirer must be notified at	Completed by Funeral Director	10e. Street and Number 18 Walnut Stree	_			10f. Zip		0.0			10g. Citiz	en of What Co	•	
	s 23e	erai			ant Francis II C	10	Was David	2178		1-0 (0)	. V N-	T.4	U.S.A		
40	ter de Itam	Ę.	11. Marital Status 1 ☐ Never Married 2 → Marr	Armed Force		. 13.	If Yes, spec	ify Cubar	n, Mexican	, Puerto Ric	y Yes or No- can, etc.)	'	<ol> <li>Race · Ame Black, Whit</li> </ol>		
036	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	1.5		1 ☐ Yes 2	Z No	Specify:				Specify: WI	nite	
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	filed with Hygiene. othar than	S	11	()			Cook		10.11.1				tor Cu	llen	
Maryland	i be fi	To Be	17. Father's Name (First, Middle, Francis William		r.					rs Name (F lotte	First, Middle,	Maiden S	Sumame)		
Z	should be and Mental is marked o	2	19a. Informant's Name/Relations	C-011 -12-11		19h Maili	ng Address	(Street a				r City or	Town, State, 2	in Code)	
Ma	nd 2 s Ith an 27 is r trau		Connie S. Welc										and 217		
ē,	f Health itam 27 other tr		20a. Method of Disposition		20b. Plac	ce of Dispo	osition (Nam matory or ot	e of		Date	9	20c. Loc	ation - City or	Town, State	
E	Page nent o nrt: If rry or		1 X Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (S							12/2	4/04	Fred	erick,	Marvla	nd
21. Signature Fulgrat Service Consessor ROBERT E. DAILEY & SON FUNERAL HOMES, P. A 615 FAST MAIN STREET, THURMONT, MD 21788										P.A.					
										Approxima	te				
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687	ficate p phys ts the			d											
Вох	death certifica attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7					23	3d. Date of deli	very	
	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ 10		h 2 ☐ Fetal de nt at time of dea		Ectopic pre Other (spe						Month	Day	Year
P.0	at the de by the a stached t	hys	9 Unknown	ļ											
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æ	The lav	mo								i	autops perform	med2 No	prior to death?	ompletion of c	ause of
Vital		Be C	25. Was case referred to medical						26. Place	of Death (C	Check only on		, , , , , ,	22.110	
of V	di S	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	eatient 2 EF	Q/Outpatier	nt 3 🗆 DO	A Other	. 4 □ Nur	sing Home	5 🗌 Reside	ence 6	Other (Spec	ify)	
	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pendin	28a. Date of (Month,	Injury 21 Day Year) 21	8b. Time of Injury	f 28	Bc. Injury Work	at ?	28d	I. Describe ho				
Sio	Attending r death. actor: After by the fune	cat	2 Accident investig	not be	( faire Albara		M		es 2□N		1				
Division	- 0	Certification:	4 ☐ Homicide determ	ined 286. Place of building	f Injury · At hom , etc. <i>(Specify)</i>	e, rarm, str	eet, ractory,	опісе		281.	City or Town	reet and n, State)	Number or Ru	rai Houte Num	iber,
	To tha Hospital or within 24 hours afte To tha Funaral Dirr completely filled in I		29a. Certifier 1 Certifyin (Check only 2 Medicel	g Physicien: To the b	est of my knowle	edge, deatl	h occurred a	it the time	, date and	d place, and	due to the ca	ause(s) a	nd manner as	stated.	
	tha H hin 24 tha Fi	Medical	Cite)	Examiner: On the bas and manne	r stated.	ri and/or in				n occurred					5)
	To To	<	29b. Signature and title of certifie	MD				License		314			signed (Month		OC 4
,	1		30 Nation and address of account		of death (New C	(2a) (Tues							mber		
	り		30. Name and address of person BINDU GEO	2GE 41			as To	HN.	son	DRIV	Æ F	RED	ERICK	MD 2	1702
*	Sta Registr		31. Date filed (Month, Day, Year)	2 2 2004	gistra s Signatur	, <b>/</b>	Low								

				State of Maryla	and / Dep	artmen	t of H	ealth a			jiene	0.1	10017
		_	State Registrar		Ce	rtificate	e of L	Death		2. Date of Dea	3,	<u>U 4</u>	42241
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	/Medic	al -	Louis Gof  4a. Facility Name (If not institution, give st			4h City	Town or	Location of		Decembe		ZUU4 ity of Deeth	9:30 AM
	Examin	er	Shady Grove Nursing &	- Rehabilitatio	n Center		kvil					tgome	ry
	Funeral		5. Social Security Number 6. Sex	7. Age (In )	rs. last birthday		1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	Year)	9. Birthp	elace (State or Foreign otry)
	Director		285 <b>-</b> 24 <b>-</b> 2487	M 2□F 74	Yrs.	Moritis	Days	nours	14111.	July 20	, 1930	Ohi	Ö′′
Т	pu k	F	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation						1	0d. Inside City Limits
	faryla sho	5	Maryland Frederic		Frederi								1 ☐ Yes 2 ☐ Xlo
	28a-i	rect	10e. Street and Number			10f. Zip			T.		10g. Citizen o	f What Cour	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Medical Examinat must to multified at	Funeral Director	3934 Loch Ness	Court		2	1704			11	U.S.A	L •	
	deatl	ner	TI. Maritar States	Was Decedent Ever i Amned Forces?	n U.S. 13	. Was Dece	dent of Hi	spanic Ori n, Mexicar	gin? (Spec n, Puerto R	cify Yes or No- tican, etc.)	14. R	ace - Americ lack, White,	
8	or Its	by Fu	1 Never Married 2 Married	Amed Forces?  XXYes 2 No If Yes, Give Kores Year or Dates.	an War	1 🗆 Yes	2[ <b>X</b> No	Specify:			Spec	ity: Whi	te
2-003a	hours tural		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ		16a Daa	edent's Usua	al Occupa	ation			16b. Kind of	Business/In	dustry
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7 7	e filed within al Hygiene. I other then vent, I'm Mei	mo	Elementary/Secondary (0-12)	(1-40/ 54)	Vice	Pres	iden				Bank		
Ē	al Hyg	Be C	17. Father's Name (First, Middle, Last)	la.						(First, Middle, e E. Di		ате)	
yiand	should be and Mental marked c	2	Lewis G. Wood		100 110		(0)			Route Numbe		m State 7in	Cadal
Mar	C1 40 40		19a. Informant's Name/Relationship (Type Mrs. Gezil C. Wood							rederi			
-	1 and Health tem 27		20a. Method of Disposition		b. Place of Disp	position (Na	ne of	(a)	Da	ate	20c. Location	n - City or To	own, State
2	Pages nent of int: If it iry or o	1	1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	Smithsbu			Ja	in. 1	, 2005	Smith	sburg	, Maryland
Baitimore	permit. Pages Department of important: If i any injury or o		21. Signature of Funeral Service License		00255	r keene	y Addre	d Bas	Ford	PA Fun	eral H	lome	1701
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	ie be executed ysician and e burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	economo of):					_			
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687	tificate ng physi as the l	dica	0	·									
Box	S	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr		DE et en ei e						Date of deliv	
ğ		iciai	in the past 12 months?	1 Live birth 2 4 Pregnant at time		B⊟Ectopic p □ Other (s)					'	Month	Day Year
0	that the de ad by the detached	hys	9 Unknown	9□ Unknown						22 214			ha a a a a a a a a a a a a a a a a a a
	res that signed I be det	by F	Part II. Other significant conditions con	itributing to death but no		underlying PE	cause giv	en in Part	l.	238. Dia to			he cause of death?
ord	v requir been si should	ted	SQUAMOUS CE		CA C.	To C				-			
Division of Vital Records,	as s	Completed by	INSULIN DEP	endant d	INDE	65	ME	41	US	24a. Was autop perfo		prior to co death?	opsy findings available impletion of cause of
a	ician: Th certiticate ector, pag		20 11 11 11 11 11					OC Plac	a of Dooth	1 ☐ Yes (Check only o	2 No	1 🗆 Yəs	2□ No
⋚	siciar certifirecto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	2 ER/Outpat	ient 3 D	OA Oth	or 4		ne 5 Resid		Other (Speci	h)
ŏ	Phys ar this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea		of	28c. Injur Wor	y at		28d. Describe			,,
<u>o</u>	nding ath. r: Atte	atlo	1 Natural 5 Pending 2 Accident investigation	(Monal, Day 1 ea	ar) Injun	М		Yes 2□	] No				
ĭ₹	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of tnjury - building, etc. (S	At home, farm, pecify)	street, facto	y, office		2	28f. Location (S City or Tox		mber or Rur	al Route Number,
	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		id a value a	To the best of an			d as the size	- data a	nd place of	and due to the	cause(s) and	manner as	stated
	Hosp 24 ho Fund stely fi	Medicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	mination and/or	investigatio	n, in my c	pinion, de	ath occurre	ed at the time,	date and plac	e, and due t	o the cause(s)
	othe othe omple	Me	29b. Signature and title of certifier			29	c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)
)	- > - 0		John _			I	25	\$65	6	T	ECEME	死3	1,2004
	4		30: Name and address of person who co	ompleted cause of death	(Item 23a) (Typ	oe, Print)	Dal	طد مد	700	ROXI	V SILL I	- 11.1-	DOMOCH
	U		RAVI VASSI, ND, 15	5225 SHA		OVE	Ker	W #	2000 H	1200	-VIL	t 1V1.	1 20000
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	oignature	. 40 -		/	,			/	
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			- For Amend Item 24	State of Maryland, a per Verb., G8	/ Depa 39 <u>0</u> 1	rtment of H 106/05/21 tificate of L	ealth and 905 9eath	d Mental Hyg	iene () (	1	422	48		
78	Physici		1. Decedent's Name (First, Middle, Last)  CLARENCE WILBER	2. Date of Deat Month	Day	Day Year		Death						
je e	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of D	DECEMBE eath	4c. County		4:05	P M		
	(A) (B)		FREDERICK MEMORIA		histo da . I	FREDERIC	K If Under 24 I	Hrs. I a Date of Birth	FREDE		(04-4-			
	Funeral Director		5. Social Security Number 6. Sex 150 150 150 150 150 150 150 150 150 150	M 2□ F 7. Age (In yrs. last	Yrs.	Months Days		frs. 8. Date of Birth fin. (Month, Day, Jul 29,	1919	Yenti Kenti	ice (State o y) 1Cky	r r-oreign		
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation				10	d. Inside Ci	ty Limits		
	e Mary ie-f sho	ctor	Maryland Freder:	ick		Knoxville	2				1 🗌 Yes	2 [X]No		
	23a or 28	rai Director	10e. Street and Number 244 Knoxville Road	d		10f. Zip Code 217	'58	1	0g. Citizen of V		ry?			
36	be filed within 72 hours atter death with the Maryland hal Hygiene. id other than "naturel", or Itams 23a or 28e-f show evant, Ita Medical Eracificar must be rodified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1		Was Decedent of Hi f Yes, specify Cuba I□Yes 2🙀 No	spanic Origin? n, Mexican, Po Specify:	? (Specify Yes or No- uerto Rican, etc.)		e - America k, White, ei : Whi	tc.			
21215-0036	within 72 ho ene. than "natur he Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	working	Golf									
Maryland 2	uld be filed within fental Hygiene. rked othar than ' tic evant, Ine Me	To Be Co	17. Father's Name (First, Middle, Last) Unknown				18. Mother's Unkn	Name (First, Middle, I	Maiden Surnam	Θ)				
	s 1 and 2 should be f Health and Mental itam 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type Mrs. Mairam Tyery)			•		r Rural Route Number Knoxville						
Baltimore,	Pages 1 and 3 nent of Health int: If itam 27 iry or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	ceme	etery, cren	sition (Name of natory or other place ape1 Ceme		Date 29, 2004	20c. Location - 4 Libe	1	m, State wn , M	D		
Balti	permit. Pages of Department of Biggraph of Important: If its any injury or of once.		21. Signature Funeral Service Line		22	. Name and Addres	s of Facility	rd P.A. Fu St, Freder		Home	nd 217	7∩1		
150	<u>.</u>		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final	cations that caused the death. I e cause on each line.	Do not ente	er the mode of dying	g, such as car	diac or respiratory arre	est,	í	Approximate Interval Bett Onset and I	e ween		
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequen		4 BART	DISA	ASE		2	-3 91	TARLS		
8760,		al Examiner	Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen										
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ds, P.O.	juires that the de signed by the a lid be detached t	by	Part II. Other significant conditions con		-		en in Part I.		pacco use contr		cause of d			
I Records,		Completed		/				24a. Was a autops perforr	y ned?	Vere autops rior to com leath?	sy findings a pletion of ca 2 \( \sum \text{No} \)	available ause of		
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: 1 ☑ Inpatient 2 ☐ ER		Othe		Death (Check only on						
of	ding Phys h. Atter this funeral dii	tion: To	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		Outpatien b. Time of Injury	28c. Injury Work	at	ng Home 5 Reside 28d. Describe ho						
Division	al or Attanding s after death. I Diractor: Atter d in by the funer	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injury - At home building, etc. (Specify)	28e. Place of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: Alter th completely tilled in by the funeral	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowle ter: On the basis of examination and manner stated.	dge, death and/or inv	n occurred at the tim vestigation, in my op	e, date and pointion, death o	lace, and due to the ca	use(s) and ma ate and place, a	nner as sta and due to t	ted. he cause(s	)		
)	To the To the comp	Me	29b. Signature and title contifier	15 9 mil	1	29c. License		499	9d. Date signed					
	5		30. Name and address of person who co Ronald E. Miller,	M.D. 4 Culwel	1 Dr	ive, Moun								
	Sta Registi		31. Date filed <b>AN</b> th <b>(</b> Pa <b>6</b> Y <b>2</b> (105	32. Registrar's Olgnatur	porti									

			1 - For State Registrar	State of	Marylan			nt of He te of D		d Me		giene Reg. No.	nnI	42	249	
	Physicia		1. Decedent's Name (First, Middle, L Bertha Zlochive								Date of De Month	Day	Year 1, 2004	3. Time 6		
	/Medic Examin		4a. Fecility Name (If not institution, g		nber)			dy Sp	Location of D		<del>o o o mo</del>	4c.	4c. County of Death  Montgomery			
	Funeral Director		022-07-5042	Sex 1☐M 2XF	7. Age (In yrs. 92	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Min.	Date of Bir (Month, Da )1/30/	th v. Year)	9. Biri	hplace (State untry) sachus		
Maryland	f show	tor	Usual Residence of Decedent	k		y, Town or Lo	cation							10d. Inside (	City Limits	
with the	or 28e	Director	10e. Street and Number			ip Code	<u> </u>			-	izen of What Co	ountry?				
OUSO hours after death v	if, or items 23s	by Funeral	63 Highland Str  11. Marital Status  1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Dece Armed For	rces? 2 ሺ No e		Was Dece f Yes, sp	2021 edent of His ecify Cubar 2∑No	spanic Origin n, Mexican, P Specify:	? (Specification Rice)	y Yes or No can, etc.)	U.S	14. Race - Ame Black, Whit Specify: W	e, etc.		
within 72 hou	ene. than "nature na Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	kind of w DO NOT	ual Occupa ork done d use retired)	uring most of	working			ealthcare						
ld be filed	ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Morris Labunsky						18. Mother's Eva I							
e, Mary	permit. Pages I and 2 should be lied within 72 nous after useful with the maryand Department of Health and Mental Hygiene. Department of Health and Mental Hygiene in Inportant: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, if a Medical Esaminar mast be ricilited at once.	L	19a. Informant's Name/Relationship Bronna Zlochiver	, , ,			Wind	rush			ly Spr	ing,	Maryla	nd 208	60	
Saltimore	tment of h tant: if ite slury or of		20a. Method of Disposition  1 Burial 2 X Cremation 3  4 Donation 5 Other (Special Control of the	cify)	State	Linco	natory or 1n C	remat	ory 12	2/15/	2004	Bre	ntwood,		and	
De de	Depar Impor any in		21. Signature of Full et al Service Lic	ean W		1	040	Rockv		Pike,		vill	ute e, Mary	land 2		
	ysician Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Cong	estive	Heart.			g, such as car	TGIAC OF IT	espiratory a			Interval Be Onset and Years	etween I Death	
	hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Chro	or as a consector or as a consector or as a consector as a consector or a consector or as a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a consector or a cons	emia quence of):										
death death	ittending or use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No   23c. If Yes, outcome or pregnancy in the past 12 months?  4 ☐ Pregnant at time of death in the past 12 months?					3 □Ectopic pregnancy 5 □ Other (specify)					23d. Date of delivery Month Day Year		
Ords, P.O	n signed by the a uld be detached i	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to								the cause of obably 4					
The law	ate has been sig page 2 should b	Completed		24a. W au pei 1  Ye					prior to completion of cause death?			s available cause of				
Off Of VItal	is certific director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigal	26. Place of Death (Check only one)  DOA Other: 4 Nursing Home 5 Residence 6 X  28c. Injury at Work? 1 Yes 2 No												
UIVISION tal or Attending	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determine	actory, office 28f. Location (S City or Tow				Street an wn, State	d Number or R	ural Route Nui	mber,					
he Hospi	n 24 hou he Funer pletely fill	edical		Physicien: To the eminer: On the ba and mann								date and	d place, and due	to the cause	(s)	
		M	29b. Signature and title of certifier	que_									29d. Date signed (Month, Day, Year)  December 16, 2004			
2	4		30. Name and address of person with Dr. Chitra Rajag		e of death (Ite			Dr.	#327 <b>,</b>	01ne	ey Mar	y1an	.d			
	, Sta Registi		31. Date filed (Month, Day, Year)  DEC 20	32. R	egistrar's Sign			och								

		1 - State Registrar			Certifica	ate of Dea	th	2. Date of De	Reg. No. 4	004	422	
Physici /Medic Examin		Decedent's Name (First, Middle, Le  Eleanor  4a. Facility Name (If not institution, gir	Diana			_			Day 27,	Year <b>2004</b> nty of Death	3. Time of Dea	
Funeral Director			Sex 7. Age	(In yrs. last bii	Yrs. Month		ider 24 Hrs. Irs Min.	8. Date of Bir (Month, Da			mery Sinthplace (State or Fore Country)  WYORK  10d. Inside City Limit	
28a-f sho	Director	Maryland Montgo	mery		r Sprin	g Zip Code			10g. Citizen		1 ☐ Yes 2 ☐	
perfittire Tagges I and 2 should be lifed within 72 hours after beaut with the manyang Department of Health and Mental Hygiene. Department of the 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	5 Schildler Cour  11. Marital Status  1 Never Married Amarried 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Tyes 2 1 If Yes, Give Year or Dates:	lo	1 ☐ Yes	20903 cedent of Hispanic pecify Cuban, Mex 25% o Special Occupation	ecify Yes or No Rican, etc.)	Spe	Black, White, cify: <b>W</b> l	White		
Hygiene. Hygiene. Ihar than "nai nt, the Medic	Completed	(Specify only highest gi Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las	+)	(Give kind of t life. DO NOT	work done during i use retired) ident			Montgomery County Board of Education  ddle, Maiden Sumame)  edo  umber, City or Town, State, Zip Code)				
and Mental the same series and marked of summaric even	To Be	George Guarino  19a. Informant's Name/Relationship	198	o. Mailing Addre	Au	relia	Loffred					
nt of Health I: If itam 27 i		Ricardo D. Zappor  20a. Method of Disposition  Assurial 2 Cremation 3	Removal from State	20b. Place o	of Disposition (A	iler Coun lame of r other place) ven Cem.	ŗ	Date	20c. Location	n - City or To	own, State	
Departme Important any injury once.		4 □ Donation 5 □ Other (Spec 21. Signature of Funers Syrvice Lice			22. Name	leaven Cem. 12/20/2004 Silver Spring, Mary1  Name and Address of Facility Hines Rinaldi Funeral Home  100 New Hampshire Ave Silver Spring, MD 2090						
Wedical / Asician and purial-transit	1		mplications that caused y one cause on each lin	the death. Do	not enter the m	ode of dying, such	n as cardiac	or respiratory a	rrest,		Approximate Interval Betwee	
Medical kaminer	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	a. Hemorrh  Due to (or as a  b. Due to (or as a		of):	nce Traing, such	h as cardiac o	or respiratory a	rrest,		Approximate Interval Between	
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has been signed by the attending physician and inpopulate a should be detached for use as the buriat-transit as 5 or	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause fits the death of the Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	a. Hemorrh  Due to (or as a  b. Due to (or as a  c. Due to (or as a  d.   23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	agic 0 a consequence a consequence a consequence of pregnancy 2   Fetel death	of):  of):  of):  of):  Of):	pregnancy	n as cardiac o	23e. Did t	23d.  obacco use c Yes 2 \( \subseteq \text{No.} \) an 24 psy primed?	Date of deliver Month ontribute to to 3 Protein to cool death?	Approximate Interval Betwee Onset and Dea	
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			1 - For State Registrar	State of Mar		rtment of He tificate of De			ygiene2004 4225				
	Physician /Medical					Ayres		2. Date of Death	Day 2 Year 7: 41 1				
	Examir			Aryland Mea		1	more		4c. County of	unty of Death			
	Funeral Director		5. Social Security Number 6. Security Number 217–28–3869	7. Age (	Yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 4		9. Birthpla Countr	ace (State or Foreign ry) PA		
	hours after death with the Maryland tural, or items 23s or 28s-f show of Example or trust be rudified at	tor	10a. State 10b. County  MD Worceste		Oc. City, Town or Lo	cation				100	d. Inside City Limits 1 XYes 2 No		
	vith the	Director	10e. Street and Number	g. Citizen of W	y?								
	ns 238	Funeral	10534 Trappe Rd.	12. Was Decedent Ev	er in U.S. 13. V	21811	panic Origin? (Spe	ecify Yes or No-	U.S	- Am erica	n Indian.		
920	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. itiam 27 is markad other than "natural", or items 23a or 28a-1 show other traumatic avent. It is Medical Example at russ Le restified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	11	Vas Decedent of Hisp Yes, specify Cuban, ☐ Yes 2X No	Mexican, Puerto Specify:	Rican, etc.)	Black	, White, et Blac	tc.		
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212	d within 72 giene. ir than "nai	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		Babysitter	<u>.</u>		Priva	te Fa	milv		
pue	be filed ntal Hygia ad othar avent.	Be	17. Father's Name (First, Middle, Last)					(First, Middle, M					
Maryland	2 should be and Mental Is markad c	ပ	Upshur Coard, Sr.  19a. Informant's Name/Relationship (T.	/pe, Print)	19b. Mailin	g Address (Street and	Mary C. I		City or Town, 5	State, Zip C	Code)		
	1 and 2 Health a am 27 Is		Debbie Ayres Mile	s/daughter	P. O.	Box 74, M	Marion, N	MD					
altimore,	Pages 1 nent of H ant: If ital		20a. Method of Disposition 1 □8urial 2 □ Cremation 3 □			sition (Name of natory or other place)			Oc. Location - (	•	n, State		
altin	- + # · =		*4 □ Donation 5 □ Other (Specify, 21. Signature of Fundamental Service Lines		22	AME Cemete  Name and Address	of Facility		Newark	, MD			
ä	Department Important Impor		21/10		1	ewis N. Wa 618 West F	Rd., Sal	isbury, 1	MD 2180				
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	/Medical Examiner		resulting in death)  Sequentially list conditions,	to P	en the not	Mascul Mascul	ar dise	ease		4	years		
8760,	cate be executed physician and the burial-transit	ai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):	An'lune	20 to	Sepsis	<u>-</u>	4	t months.		
P.O. Box 687	The law requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery	/ Day Year		
	luires that n signed b	by											
Vital Records,	The law requir ate has been s page 2 should	omplete											
Vital	(U Late	Be	25. Was case ref-rred to medical examiner?	Hospital:	001102 10			(Check only one					
of	ding Phys h. After this funeral di	tion: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day )	28b. Time of	28c. Injury at Work?	4 [] Huising Ho	me 5 Resider 28d. Describe how					
Division	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 6 Suicide 7 Suicide 8 Suicide 8 Suicide 8 Suicide 9 S										
	e Hospital or 124 hours afte a Funaral Dir letely filled in	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.									ed. he cause(s)		
)	To the lead the lead to the le	Me	29b. Signature and title of certifier		<b>2</b> 0	29c. License n	17223	29 D	d. Date signed	(Month, Da	gy, Year)		
(	y My		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type, I	ersily of	F MAG	Hand n	hodial	Cen	fe Green 344more, Mo		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Spork		,	- COL	1.	3 Affirmere, Mo		

			1 - For State Registrar			ate of	Marylan		artmen rtificat			and M		Reg	ne <sub>2</sub> (	004	422	252
	Physic	ian	1. Decedent's Name (F)		•								2. Date of Month		Day	6 23	3. Time of	
	/Medi		Bertha 4agFacility Name (If not	Mae			delotte		4h City	Town or	Location of	of Death		2		nty of Death		<b>2</b> M
	Exami	ier	Peninsula	Ree	inal	M	dical	antes	No. Only,	Sal	IShu	121			U	Com		
	Funeral		5. Social Security Numb	er /	6. Sex 1 ☐ M		7. Age (In yrs.	,,	If Under Months	1 Year Days	If Under		8. Date of	of Birth	ear)		place (State ontry)	r Foreign
	Director		213-22-6357 Usuel Residence of Dec	7	1 LJ M	2103 F	77	Yrs.		22,0			Novemb				land	
	yland sow			b. County			10c. Cit	y, Town or Lo	cation								I 0d. Inside Ci	ty Limits
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	vith th	Director	10e. Street and Number	•					10f. Zip	Code				10g	. Citizen	of What Cou	ntry?	
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	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Ma	BeC	17. Father's Name (First	t, Middle, L	ast)			_ rronte	usicz)		18. Mothe		(First, Mi					
ylaı	should b nd Mente marked umatice	To E	Alfred	W.	1	Rohm					Jenr					Warr		
Maryland		N	19a. Informant's Name/			, ,										vn, State, Zip		0.40
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	be sit	iner	Sequentially list condition any, leading to immediate. Enter Underlying Cause (Disease or injur	nis, nate g		Due to (or as a consequence of):  Gthimtelization Distance											-	
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8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit				d													
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Вох	death certifica attending ph d for use as t	lan/	23b. Was decedent pre- in the past 12 mon		1.	Live bir	ome of pregna th 2 ☐ Fetal	Ideath 3□	Ectopic pre							Date of delive		ear
Ö	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			_ Pregna ☐ Unknov	nt at time of de vn	eath 5	Other (spe	ecify)				_		NOTION	Day 1	bai
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a H				0/12	28 · f · i	\$							1 🗆 Y	erformed es 2		death?	2 🗆 No	
V:	Physicien: this certific ral director,	o Be	25. Was case referred to examiner?  1 Yes 2 No	o medical	Hospita	al: 1 (\$170)	patient 2	ER/Outpatien	t 3 DO	Othe	26. Place		-		- 0.000	W (O )		
	ding Phys h. After this funeral di	$\vdash$	27. Manner of Death			a. Date of		28b. Time of Injury		Bc. Injury Work			8d. Descr			ther (Specif) urred	′)	
sior	Attendin death. ctor: Af y the fur	atio	2 Accident	☐ Pending investiga	ition	(101011111	, Day Tour,	rijury	М		es 2 🗆 N	10						
Division	or Attendation of the order of the order or orde	ertification;	3 Suicide 6 4 Homicide	Could no determin		e. Place o building	of Injury - At ho g, etc. <i>(Specil</i> y	me, farm, stre	eet, factory,	, office		2		on (Stree Town, S		nber or Rura	l Route Numb	er,
_	spitel	O	29a. Certifier	Certifying	Physician	: To the b	est of my kno	wledge, death	occurred a	at the time	a date and	1 place, a	nd due to	the caus	e(s) and r	nanner as st	ated	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	(Check only 2	Medical E	xamıner: 🤇	n the bas	is of examinal	tion and/or inv	estigation,	in my opi	nion, deat	h occurre	d at the ti	me, date	and place	e, and due to	the cause(s)	
	To t To t	Σ	29b. Signature and title	et certifier	5 (.		$\geq$			License					Date sign	ned (Month,	Day, Year)	
•	6-		- ruel	للما	C 00	-		V - 1192-1-214		56C								
	MP		30. Name and address of the check of the che		go complet							102	20-7	Mo	2,80			
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		1 - For State Registrar	State	of Maryla	•	artment of H rtificate of I		and ivi	_	grene U Reg. No.	UL	42253			
Characteria		Decedent's Name (First, Middle	e, Last)		<del></del>		-		2. Date of De		Year	3. Time of Death			
Physicia /Medic		Daisy Esth	ier Au	stin					Dec.	18	, 2004	12 <b>:</b> 15 <b>A</b> <sup>M</sup>			
Examin		4a. Facility Name (If not institution				4b. City, Town, or					ity of Death				
		Salisbury Nurs 5. Social Security Number			enter	If Under 1 Year	Sali If Under 2		y, Md. 8. Date of Birt		omico	(0)			
Funeral Director		216-14-9200	6. Sex 1 ☐ M 2 🔀 F	8 4	Yrs.	Months Days	Hours	Min.	Nov 13	1920	Count	ace (State or Foreign ginia			
death with the Maryland ms 23a or 28a-f show rount be notified at	<u>.</u>	Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo						10	od. Inside City Limits 1 ☐ Yes 2 XNo			
the M	Director	Maryland Wic	comico		Quan	10f. Zip Code				10g. Citizen o	f What Count				
with with		2534 Giles I	ano			2185	5.6			U.S.		,.			
death	Funeral	11. Marital Status	12. Was De	cedent Ever in	n U.S. 13.	Was Decedent of H If Yes, specify Cuba		gin? (Spe	acify Yes or No		ace - America				
72 hours after death w hatural', or Items 23a dical Examinar must b		1 ☐ Never Married 2 ☐ Mar		Forces? 5 2 No		1 ☐ Yes 2 No	an, мөхісап Specify:	i, Puerto	Hican, etc.)		lack, White, e	etc.			
ours iral',	d by	3 Widowed 4 □ Divorced	Year or	Dates:		•				Spec	Bla	.ck			
"natural",	ete	15. Deceder (Specify only highe	nt's Education est grade complete	d)	(Give	dent's Usual Occup	durina most	t of worki	ing	16b. Kind of	Business/Ind	ustry			
filed within 72 hours after Hygiene. Ither then "natural", or Ite ent, the Madical Examina	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 7  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use relired)  Domestic  17. Father's Name (First, Middle, Last)  Alfred Jubilee  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use relired)  None  18. Mother's Name (First, Middle, Maiden Surmame)  Sudie Jubilee														
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, it a Magnes.															
Should Me mark	Ĕ	Alfred Jubilee  19a. Informant's Name/Relationship (Type, Print)  Calvin Austin Jr. (Son)  20a. Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition (Name of cemetery, crematory or other place)													
nd 2 alth ar 27 is r trau															
item item															
Pages nent of ant: If it ury or o		'4 □Donation 5 □Other (S			uantico	Cemete	ry 1		3-04	Quant	ico,M	d.			
permit. Departr Importi		21. Signature of Funeral Service	B. Ste	war	1 25	Name and Address ELEWART 21 West	ss of Facility Fune Rd.	ral:	Home	,Md.2	1801				
* .		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that only one cause or	t caused the d	eath. Do not en	ter the mode of dyin	ng, such as	cardiac c	or respiratory ar	rrest,		Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition	a Coly	one	fer	Tracker	رع	10	Game	ey d	ween	Onset and Death			
/Medical Examiner		resulting in death)	Due	o (or as a cons	sequence of):					/		7			
LAGITIMICI	-	Sequentially list conditions, if any, leading to immediate	b. Due	of lovas a cons	sequence of):	- sur-					5	Per-			
nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	<	201	A Co						/ _	- 0 B-			
execute in and ial-trans	Еха	that initiated events resulting in death) Last	Due f	o (or as a cons	sequence of):							20(7			
icate be executed physician and the burial-transit	cal		d												
ntifica ng ph	an/Medical	IF FEMALE:	I												
requires that the death certificate be neen signed by the attending physici hould be detached for use as the bu	lan/I	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pre birth 2 🗆 F	etal death 3	⊒Ectopic pregnancy	,			1	ate of deliver	y Day Year			
that the death	hyslci	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pre 9□Un	ignant at time o known	of death 5L	Other (specify)									
res that the signed by	₾.	Part II. Other significant conditi	ons contributing to	death but not	resulting in the u	inderlying cause giv	en in Part I.	,	23e. Did t	obacco use co	ntribute to the	e cause of death?			
quires n sign	d by								1 🗆 🗅	Yes 2□No	3 🗀 Proba	ably 4 Unknown			
aw requir as been si 2 should	ompleted								24a. Was		. Were autop	sy findings available			
و يو	mo									osy rmed?	prior to com death? 1 \sum Yes	ppletion of cause of			
	3e C	25. Was case referred to medica	11				26. Place	of Death	(Check only o						
00	To B	examiner? 1 ☐ Yes 2 ☐ HO	Hospital: 1 [	☐Inpatient 2	2 ☐ ER/Outpatie	nt 3 DOA Oth	er: 4 Hu	rsing Ho	me 5 Resid	dence 6 🗆 O	ther (Specify	)			
ing Pl	on:	27. Mann f Death 1 Natural 5 ☐ Pendi		te of Injury onth, Day Year	r) 28b. Time o	Wor	k?		28d. Describe l	how injury occi	urred				
Attanding or death.	icati	3 Suicide 6 ☐ Could	not be	co of Injune - A	At home form of	M 1	Yes 2 🔲 î	-	28f Location /	Stroot and Nur	nher or Rural	Route Number,			
al or Attanding Phys s after death. I Director: After this din by the funeral d	ertificati	4 ☐ Homicide determ	nined bu	ilding, etc. (Sp.	ecify)	reet, factory, office			City or Tov		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	riodio ivamoci,			
Hospit 4 hour Funara tely fille	edical C	29a. Certifier 1 Certifyi (Check only 2 Medical	Examiner: On the	the best of my basis of exam anner stated.	knowledge, deal nination and/or in	th occurred at the tire evestigation, in my o	me, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and r date and place	manner as sta e, and due to	ated, the cause(s)			
To tha within 2 To the complet	Me	29b. Signature and title of certific		2		29c. Licens	e number			29d. Date sigr	ned (Month, L	Day, Year)			
)		1	7/1			08	2-83	74	1	12/	20/14				
11111		30. Name and address of person	who completed co	ause of death (	Item 23a) (Type,		100		1		14	01004			
( , , ) ,		William H	Robin	s m.	D.	2	200 Ci	Vic	Ave.,Sa	alisbur	y, Md.	21804			
Sta	te	31. Date filed (Month, Day, Year		. Registrar's Si	ignature 4	loca V	,								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Denartment of Health and Mental Hydiene? 0.01.

		-	- State Amend Item	1&Unpend It	aryland/Dep em 23a,pt. <i>Ce</i>	artment of Hear rtificate of De	alth 6840 <sup>M</sup> 2 <u>nt</u> eath	al Plygler 8eg. N	SC 0 0 4	42254			
	Physici	an	1. Decedent's Name (First, Middle, I Aldana Amedeo Amadeo Aldana				2. Da	ate of Death	ay Yeer	3. Time of Death			
	/Medic	al	Amadeo Aldana  4a. Facility Name (If not institution, c	ive street and number)		4b. City, Town, or Lo			20,2004 Ic. County of Deatl	11:28a. M			
	Examin	e L	115 SILOPANNA ROA			ANNAPOLIS			ANNE ARUN				
	Funeral		5. Social Security Number 6	.Sex 7.Ag	e (In yrs. last birthday)		f Under 24 Hrs. 8. Da Hours Min. (M	ate of Birth fonth, Day, Yea	9. Birtt	nplace (State or Foreign untry)			
	Director		none Usual Residence of Decedent	MAIM 2LIF	46 Yrs.		Apr	i1 2, 1	L958 E1	Salvador			
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits			
	a-feh	ctor	Md. Anne Ar	unde1	Annapoli	s				1∭XYes 2□No			
	or 28	Dire	10e. Street and Number	1		10f. Zip Code 21401			Citizen of What Co				
	s 23s	eral	115 Silopanna Ro	12. Was Decedent	Ever in U.S. 13				El Salvad				
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f ehow any injury or other traumatic event, the Madinal Exp. directional by notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Armed Forces?	No	Was Decedent of Hispa If Yes, specify Cuban, I 1X Yes 2□ No	Mexican, Puerto Rican Specify: Salvad		Black, White	e, etc.			
5-0	72 ho	eted	15. Decedent's (Specify only highest	Education	16a. Dece	edent's Usual Occupations with done during the DO NOT use retired)	on ring most of working	16b.	Kind of Business/	Industry			
21215-0036	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired) ndow Cleane		T.T = 2	dor Clas				
	filed v Hygie other t	S C	17. Father's Name (First, Middle, La	st)	M T		8. Mother's Name (Firs		ndow Clea en Sumame)	ıııııg			
an	Mental Mental rked c	To Be	Juan Aldana			G	Graciela de	Aldana	1				
Baltimore, Maryland	nd 2 should be filed within 'ith and Mental Hygiene. 27 is marked other than "r rtraumatic event, the Mad		19a. Informant's Name/Relationship Wilber Alfonso F Son-in-law	o (Type, Print) Cortillo Mai	te Number, City	y or Town, State, Z	Tip Code)						
ore,	of Head of Head fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		20b. Place of Disp	olis, Mary osition (Name of matory or other place)	Date	20c.	Location - City or	Town, State			
ţi m	Pag Iment tant: i		`4 ☐ Donation 5 ☐ Other (Spe	cify)	01-07-05	111	Salvado						
Bal	permit Depar impor any in		21. Signature of Funeral Service Lie	Bacon, C	1c 361		St., N.W. V	Wash.,		10			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cause by one cause on each li	d the death. Do not en ine.	nter the mode of dying,	such as cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		arrhythmia	a							
	Examiner			b Due to (or as	a consequence or).								
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):								
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68760,	ificate be execut g physician and as the burial-trar	alE		d									
	(T) (r)	ledical											
Box	death cert e attending id for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy			23d. Date of deli	ivery Day Year			
	the dea by the at	Physician/M	1 Yes 2 No	4∏Pregnant a 9∏Unknown	t time of death 5	Other (specify)							
, P.O.	res that the de signed by the a be detached f	y Ph	Part II. Other significant condition	s contributing to death t	out not resulting in the	underlying cause given	in Part I. 2	3e. Did tobacc	o use contribute to	the cause of death?			
rds	requires that een signed b nould be deta	q pe	Alcohol use					1 ☐ Yes	2□No 3□Pr	obabiy 4 Unknown			
Records,	- 0.70	Completed by					2	4a. Was an autopsy	24b. Were au	topsy findings available completion of cause of			
Ä	The law	Com					(	performed Yes 2 1	? death?	2 No			
Vita	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Other	26. Place of Death (Che		77	COPNE			
of	Phys this	.: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpati 28a. Date of Inj (Month, Da	ent 2 ER/Outpatie	MIL SCIDON	4 [	5  Residence Describe how in		city) SCENE			
ion	nding F ath. r: After ie funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		y Year) Injury		es 2 No						
Division of Vital	al or Atte after des i Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			ocation (Street lity or Town, St	and Number or Ru ate)	ıral Route Number,					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C											
	To th withir To th comp	Me	29b. Signature and title of certifier	) A	number		Date signed (Monti						
)			•	y MI.	UN	0.C.M	т. Е.	DECE	EMBER 21,	2004			
R	(3)		30. Name and address of person w	M. Tory	m.D.	STREET BALT	'IMORE,M	1ARYLAND	21201				
	Sta Regist		DEC 3 0 200		rar's Signature	de la							

State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#2perMD12/21/04, BMW, McCo Certificate of Death Reg. No. 2. Date of Death Dec. 16,2004 1. Decedent's Name (First, Middle, Last) **Physician** NTHON 1929 GENTRUDE /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Brooke Grove Nursing & Rehab. Center Sandy Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF 75 Director 223-34-0824 Kentucky Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20905 \*natursi', or items 23a 2113 Kingshouse Rd. USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natursi", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: Specify Completed by 3 ₩ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N.I.H. Secretary 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hobart Jennings Phelps Mary Edna Mounce ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Suzanne Freeman- Daughter 2113 Kingshouse Rd. Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury of permit. Page Department of Important: If Gate of Heaven Cem. 12/21/2004 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 'n 11800 New Hampshire Ave. Silver Spring, MD 20904 Ruh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVASCULAL **Physician** ACCIDENT disease or condition resulting in death) /Medical Examiner THEROSCIEND TIC CARDIOVAJORIUM DUFATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 2 200 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No has certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funeral C Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ZYZOZOG 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 -HAMPSHIRE AVENUE NEW MO PARIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

		-	For State Registrar	State	of Maryland	/ Depa	artment of tificate o	Health f <i>Deat</i>	and M h		jier De () leg. No.	04	422	56
			1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	th Day	Year	3. Time of I	Death
	Physicia /Medic		Marie C. Allen							December			2:35	ам
	Examin		4a. Facility Name (If not institution	n, give street and no	umber)		4b. City, Town	or Location	n of Death		4c. Cou	inty of Death		
			Holy Cross Rehab.	& Nursing	Center		Burtons				Mon	ntgomery	7	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 24 ☐ F	7. Age (In yrs. las		If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Birth (Month, Day	Yea <i>r)</i>	9. Birth	place (State or intry)	Foreign
	Director	Ĺ	579-26-4552	10 M 201F	92	2 Yrs.				Feb. 23,	1912	Wash	nington,	DC
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	s 23	era	2 Ca.sey's Way	12 Was Do	cedent Ever in U.S.	13 1	19970		Origin? (Sp	ecify Yes or No-	USA 14 F	A Race - Ameri	ican Indian	
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Maryland 21215-0036	os 1 and 2 should to the stand and Ment I tem 27 is marked to the traumatic et		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address (Stre	et and Num	nber or Run	al Route Numbe	r, City or To	wn, State, Zi	p Code)	
	and 2 ealth n 27 i		Kathleen M. Steve	ns/Daughter			y's Way,	Ocean						
S.	of He of Her		20a. Method of Disposition 1   Barial 2 □ Cremation	2 Demoust from	cen	ce of Disponetery, crer	sition (Name of natory or other p	lace)		Date lber 22,	20c. Location	on - City or T	own, State	
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Baltimore,	permit. Pages Department of it Importent: If Its any injury or or once.		21. Signature of Funeral Service	Licensee	.,	F	Name and Add	Coll Fac	ility Fune	ral Home	Inc			
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death.	Do not ent	er the mode of d	ying, such	as cardiac	or respiratory arr	est,		Approximate Interval Betw	veen
	Physician :		Immediate Cause (Final disease or condition	Seps									Onset and D	eath
	/Medical		resulting in death)	a	o (or as a conseque	nce of):								
	Examiner			, Oste	mvelitis									
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	4		30. Name and address of person Marcia P. Goldma		use of death (Item 2 2 <b>309 Shoref</b> :			on. Mr	20902					
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	/Medic		Wajih S. Al-F				4b. City, T		1	-40	Decemb		County of Dea	
	Examin	er	4a. Facility Name (If not institution Suburban Hosp		поөг)			thes		or Deatri		46. (	Montgo	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Veer	9. Bir	thplace (State or Foreign
	Director		579-11-5040	1 <b>X</b> M 2 □ F	8	7 Yrs.	Months	Days	nours	MIII.	March 2			ebanon
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	h the	Director	10e. Street and Number		1		10f. Zip	Code				10g. Citiz	en of What Co	ountry?
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Maryland 21215-0036			19a. Informant's Name/Relations Kamal W. Al-Fa	er, City or shing	Town, State, . ton, Do	Zip Code) C 20016								
Baltimore,	of Hea of Hea If item		20a. Method of Disposition  Y□ Burial 2 □ Cremation	3 □Removal from	cer	ce of Dispo	natory or oti	her place	9)	Dece	Date mber 21	20c. Loc	cation - City or	Town, State
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2	Examiner				AWTE	MYO	CARD	1A	_ /	NIFA	RCTION	V		
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£ 5	Attending r death. ector: After	atlor	Natural 5 Pendir Pendir	9	th, Day Year)	Injury	М		?? /es 2 □	]No				
Divis	ol or Atte after des Directo	Certification:	3 Suicide 6 Could 4 Homicide determ	288, Flace	of Injury - At honing, etc. (Specify)	ne, farm, str	eet, factory	, office			28f. Location ( City or To			ural Route Number,
AIS	To the Hospitel or Attending Physician: The taw within 24 hours after death. To the Funerel Director: After this certilicate has completely filled in by the funeral director, page 2		29a. Certifier (Check only one)   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated. (Check only one)   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Dey, Year)   20c y    30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   Shayam											
	To the To the comple	Me												
	4		30. Name and address of person	who completed cause	se of death (Item)	23a) (Type,	Print) SV	20	am	GAT	THETUS	DUNG	G, MD	: 208+8
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 21		Registrar's Signatu	Jre &	-	uks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland (1) Continue of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1:54<sup>M</sup> Year **Physician** Gloria Book December 17, 2004 L. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury
If Under 1 Year + If Under 24 Hrs.
Months Days Hours Min. (Month, Dey, Yeer)
12/11/1930 Wicomico 1008 Riverhouse Dr., #7 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 280 F 74 Mary land Director 220-26-2851 Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State ral', or items 23a or 28a-f ehow Examiner must be notified at 1 Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 1008 Riverhouse Dr., #7 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3X Widowed 4 □ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "netur 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Nurse 12 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental P Pages 1 and 2 should be Albanus Paul Bertha Green 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Deborah L. Book/daughter 30572 Cannon Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. ö 12/21/04 Hurlock, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Soneture of Funeral Service Vicense 22. Name and Address of Facility Holloway Funeral Home Professional Association Im FR 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Motestatic Carcinona Onkrown **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 X-No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) a. o. 030690 20 306 9

31. Date filed (Month, Day, Year) DEC 2 1 2004 Registrar

Jomes E.

32. Registrar's Signature Deneva

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN M.D.

145 E. Groll 51 521.5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per Verb., G839 01/2//05dhb
Reg. Ng. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:00PM BROWN GRACE 2004 E DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT HOSPICE TAUBOT EASTON tt Under 1 Year | tt Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | APCIL 23 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 K F Yrs. 165 20 4757 77 Pennsylvania Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show in than "natural", or items 23a or 28a-f showing Medical Examinar must be notified at 1X Yes 2 No Directo Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 414 Trippe Avenue 21601 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Btack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 ☑Widowed 4 □ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lewis W. Winters Hannah May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Trippe Ave., Easton, MD if of Health Rodney Allan Brown/Son 21601 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 ← Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or once. WoodlawnMemorialPark | 05/02/2005 Easton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 308 HIGH ST. MUCH CURRAN -- BROMWELL CAMBRIDE 21613 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Immediate Cause (Final disease or condition resulting in death) **Physician** WKI /Medical Due to (or as a consequence of): **Examiner** 120041 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes of Vital 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 No 2 1 Tyes this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manney of Death 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Anaturat 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 🗌 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 | Homicide 24 hours a McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifin

State Registrar

DHMH 17 Rev 1/2001

Dr. Robert B. Sanchez, 508 Idlewild Ave., Easton, MD 21601

2004 Nasses Signature

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

EC 2

State of Maryland / Department of Health and Mental Hygien 2 1 1 42260 For State Registrar Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death - 2<u>004</u> Month **Physician** PAUL BEARD 27-3:10P 12-/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner WASHINGTON HAGERSTOWN RAVENWOOD LUTHERAN VILLAGE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1**X** M 2□ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Yrs. 80 Director 220-16-0026 Sept. 2 1924 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 27 Is marked other than "natural", or Itams 23a or 28a-1 show traumatic avant, Ita Madical Examiner must be maified at 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Winding Oak Drive 21740 U.S.A. Completed by Funeral 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 4-12-43 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 6-26-1946<sup>1 □ Yes</sup> 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) C.P.A. C.P.A. Firm 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Leslie Beard Helen Harriett Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is m Lucille S. Beard (wife) 208 Winding Oak Drive Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō 12-31-04 Cedar Lawn Mem Park Hagerstown Maryland 4 ☐ Donation 5 ☐ Other (Specify) any injury once. 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Fyneral Service Licensee 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 NIA 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End stage COPD **Physician** severed crears disease or condition resulting in death) /Medical Examiner ulmon ary Fiblosis Sequentially list conditions, ance of) Examiner cause. Enter Underlying Cause (Disease or injury Dementic The law requires that the death certificate be executed CHIONIC the burial-transi heiners that initiated events resulting in death) Last the attending physician and P.O. Box 68760, 106 Cb4 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ director, page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the To the Within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 00062223. 249T1 of person who completed cause of death (Item 23a) (Type, Print) Hagerstown Mill Street Pravcer Prolarum M.D 32. Registrar's Signature State 9 Registrar

HAMMOND

BEARD, Paul

			State of Maryland / Dep	artment of Health and Me		
			On A	rtificate of Death	Reg. No 2001	42251
	Physic	ian	Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year	3. Time of Death
	/Medi Exami		Dennis James Bloyer 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dec	1225 AM
			11428 Ashton Road	Clear Spring	Washingt	
ı	Funeral Director		5. Social Security Number 6. Sex 1 ⋈ M 2 □ F 7. Age (In yrs. last birthday,	Months Days Hours Min.	Date of Birth (Month, Day, Year) (Tober 22, 1950	inhplace (State or Foreign Country)
	D O		Usual Residence of Decedent		.10ber 22,1550	Maryland
	Manyla f shov	٥	10a. State 10b. County 10c. City, Town or Li Mary Land Washington Clear Spi			10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	h the l	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	
	ath wi	ral	11428 Ashton Road	21722	USA	
<b>,</b>	fter de r ttems ilner b	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1. Yes 2 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ric	( Yes or No- an, etc.) 14. Race - Am Black, Wh	erican Indian, ite, etc.
96	72 hours after death with the Maryland natural', or items 23a or 28e-f show areal Examiner in ust be multiled at	Ď	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Wh	ite
21215-0036	d within 72 hours after death with the Marylan giene rr than "natural", or Items 23a or 28e-f show the Madical Examiner is ust be mulfilled at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business	
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	27 is a			3 Ashton RD Clear Sp		zip code)
Baltimore,	ges 1 and to 1 Heal		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date matory or other place)		Town, State
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Ba	Depa Impo any is		1 Yatte Man	sborne Funeral Home	P.A. 425 S. Con	ococheague
			23a. Paft1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	t. Williamsport, MD er the mode of dying, such as cardiac or re	spiratory arrest,	Approximate Interval Between
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Vital Records,	or Attending Physicien: Thiter death, Director: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Ch	eck only one)	
	g Phys ter this neral di	n: To	27. Manney of Death 28a. Date of Injury 28b. Time of	t 3 DOA Other: 4 Nursing Home 28c. Injury at 28d.	5 ☐ Residence 6 ☐ Other (Special Describe how injury occurred	cify)
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Division of	tal or Attendii s after death. el Director: A ed in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 28f. I	Location (Street and Number or Ru City or Town, State)	ural Route Number,
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	5 × 5 × 5		29b. Signature and title of certifier	29c. License number	29d. Date signed (Monti	
المل و	10	+	30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	12.2	7 04
5			Michael McCornack 1111	o Medical lump	ous Hayerston	$\sim m_0$
	Sta Registra	e ar	31. Date filed (Month, Day, Year)  DEC 29 2004  32. Registrar's Signature	rented		
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	-	State				$\sim$	Certificate of	Death			Reg. No			
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DHMH 17 Rev 1/2001

			For Stete Registrar	State of M	aryland /		artment of H		and Me		giene	004	422	63
			Decedent's Name (First, Middle, Las	t)					2	. Date of Dea			3. Time of	Death
П	Physici /Medic		HELENE A.	BARCILO	N				D	Month ECEMBE	R 20,	2004	1:45	A M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location o	f Death		4c. Co	unty of Death	1	
			CASEY HOUSE - MON				ROCKV		2411			ONTGOM		
r	Funeral		5. Social Security Number 6. Se 579-68-4061	ox 7. Ag ⊒M 2527F	ge (In yrs. last i 7 1	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day	v. Year)	9. Birth Cou MORO	nplace (State of untry)	r Foreign
	Director		Usual Residence of Decedent		71				IN	OV 2,	1933	FIORC	0000	
	yland how		10a. State 10b. County		10c. City, To	own or Lo	cation	-	-				10d. Inside Cit	y Limits
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	s 23a	ra	5904 LONE OAK DRI				208		1.0.40			D STAT		
	itam:	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 \( \text{Yes} \) 2 \( \text{X} \)		13. \	Was Decedent of H f Yes, specify Cuba	ispanic Orig in, Mexican	jin? (Speci , Puerto Ri	ty Yes or No- can, etc.)	14.	Race - Amer Black, White		
936	72 hours after death with the Maryland natural', or itams 23a or 28a-f ahow Jost Esan, or must be notified at	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:			1 X Yes 2 □ No	Specify:	SPANI	SH	Sp	ecify:	WHITE	
Ö	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16	6a. Deced	ient's Usual Occup	ation			16b. Kind	of Business/I	ndustry	
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2	filed within Hygiene. Ithar than "	CO	17. Father's Name (First, Middle, Last)	5+		Th	EACHER	10 Matha	do Nama (	First Adiddle		UCATIO	N	
Maryland 21215-0036	d tal	Be	ABRAHAM PERE	7.					THER	First, Middle,	маюн эи	LASR	Υ	
Ž	should man marka	은	19a. Informant's Name/Relationship (7		1	9b. Mailir	ng Address (Street			Route Numbe	r. City or To			
	and 2 sealth ar n 27 is			DAUGHTER			LONE OAK				-	20814		Life Control
Ē,	of Head of Head fitam		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place		Dat		-	ion - City or 1	Town, State	- 5
Ë	Pages nent of I		1  Burial 2  □ Cremation 3  □ '4  □ Donation 5  □ Other (Specify		· I	-	ON CEMET		12/21	/2004	ADEL	PHI, M	ARYLANI	)
Baltimore,	parmit. Pages Department of Important: If it any injury or o		21. Signature of Fune of Service Liova	see		DA	Name and Addres	ss of Facility	ERG M	EMOR T A	I. CHA	PELS.	TNC.	
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I,			23a. Part1. Enter the disease, or comp shook, or heart failure. List only	olications that cause one cause on each li	d the death. D ine.	o not ent	er the mode of dyin	g, such as	cardiac or r	espiratory ar	rest,		Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Filed disease or condition resulting in death)	a. CONGES	TIVE H	EART	FAILURE						YEARS	
Е	/Medical Examiner		f	Due to (or as	a consequent	ce of):								
		er	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. — Due to (or as	a consequenc	ce of):								
	utad d ansit	Examiner	Cause (Disease or injury that initiated events	C										
o Ō	e exection and an arrial-tr	Exa	resulting in death) Last		a consequenc	ce of):							-	
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Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal dea	ath 3	Ectopic pregnancy Other (specify)				23d	. Date of delive Month	- ,	'ear
o.	that the de ed by the detached	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	a timo or douti	. 02	Curior (Speciny)							
S, P	es that the igned by be detact	by PI	Part II. Other significant conditions of	ontributing to death b	out not resulting	g in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of de	eath?
rds	w require baen sig should b	ed b								1 □ Y	es 2 🔀 N	lo 3 Pro	bably 4 🗆 U	nknown
Division of Vital Record	a law requ has baen je 2 shoul	Completed								24a. Was autop		4b. Were aut	opsy findings a ompletion of ca	vailable
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/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hoonital:			Oth			Check only o				
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N S	or Attending after death. Diractor: After in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of In	ury - At home,	, farm, str	eet, factory, office		28	f. Location (S City or Tow		umber or Rui	rai Route Numb	oer,
	tal or A	Certification:	4 E Homeide	building, e	tc." (Specify)				W.	Only or You	ri, Sialej			
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	To the Hospital or Attending Physician: That within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medi	one)  29b. Signature and title of certifier	and manner st	ated.		29c. Licens					gned (Month		
1			1 01-1-0	20.										
	10		30. Name and address of person who	completed cause of	death (Item 23:	a) (Tyne	D42	452			DECEM.	DEK 20	, 2004	
			CHITRA RAJAGORAL,	•	·			RIVE,	#327	OLNE	Y, MA	RYLAND	20832	2
	Sta		31. Date filed (Month, Day, Year)	32. Registi	rar's Signature		Sparks							
W.	Registr	ar	DEC 21 20	JU4   Par	man	pul	proces							

			1- State of Maryland Registrar	/ Depa		Health and	d Mental Hygi	iene 00L	42264			
	Physici	ian	1. Decedent's Name (First, Middle, Last) Brian Lee Bowdren				2. Date of Death Month	er 14, 2004	3. Time of Death			
	/Medio Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of De		4c. County of Death	2219			
	LAGIIII		450 Race Street		Ca	mbridge		Dorchest	er			
	Funeral Director		5. Social Security Number 092-46-4944  Usual Residence of Decedent	Yrs.	If Under 1 Yea Months Days		Hrs. 8. Date of Birth Min. Month, Day, June 1.	<sup>yea</sup> r) 1954 New	place (State or Foreign http:/ York			
	nyland how		10a. State 10b. County 10c. City, 1	own or Lo	cation				10d. Inside/City Limits			
Ç	the Ma	Funeral Director	Maryland Dorchester	Caml	oridge		10	Og. Citizen of What Cou	1 No 2 No			
3	3a or	io i	605 William Street		2161	3		USA	Tuy.			
2	ams 2	nera	11. Marital Status 12. Was Decedent Eyer in U.S. Armed Forces?	13.	<u> </u>		(Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White,				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 20a or 28a-f show apprint injury or other traumatic avant, its Modical Evaridies must be inclified at ance.	Completed by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		I□Yes 207No	Specify:		Specify: Wh	ite			
15-	in 72 t	olete	(Specify only highest grade completed)	6a. Deced (Give) life. L	lent's Usual Occi kind of work don DO NOT use retir	ipation e during most of i ed)	working 1	16b. Kind of Business/In	dustry			
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	be fila tal Hyg d otha avant,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's I	Name (First, Middle, M	laiden Sumame)				
yla	Ment Ment Markac	2	Robert Bowdren		eneth Van N							
Maryland	nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Cynthia S. Bowdren/Spouse		Cambridge,	City or Town, State, Zip, MD 21613	Code)					
Baltimore,	ges 1 and 2 of Health If itam 27 I		20a. Method of Disposition 1			20c. Location - City or To						
ţ	permit. Pages Department of I Important: If its any injury or of		'4 □Donation 5 □Other (Specify) MidS	noreC	remation	Center12	2/19/2004 (	Cambridge,	Maryland			
Ba	Depa Impo Impo any in		Mother Parray- Domeville	ر 30	ırran-Br 08 High	omwell I St., Car	Funeral Hom mbridge, Mi	me, P.A. 21613 _				
	Physician /Medical Examiner	Examiner	23a. Sant: Enter the discrete, or complication in that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter up of ying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence).  Due to (or as a consequence).	nce of):	eart Di		DIAC OF respiratory arre	St,	Approximate Interval Between Onset and Death			
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ds,	w requires that been signed b should be deta	b	Faith. Other significant continions contributing to death but not resulting	ig in the ur	idenying cause g	iven in Faiti.	1 \e		pably 4 Unknown			
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Vital	ysician: is certifica director, l	Be	25. Was case referred to medical examiner?				Death (Check only one	2)	01			
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	al or Atta after de Diracto d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Rura State)	l Route Number,						
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle and manner stated.	dge, death and/or inv	estigation, in my	opinion, death or	ccurred at the time, da	te and place, and due to	the cause(s)			
)	To T COM	2	29b. Signature and title of certifier  MO		0	57290		12/15/04	Day, Year)			
			30. Name and address of person who completed cause of death (Item 2:  Martin L- Garcia-Dunud, W  31. Date filed (Month) Program 7 2004  32. Refistrar's Signatur	3a) (Type,	Print)	1Um St.	Cambrida	x, MD 216	13			
	Sta Regist		DEU 1 7 2004 S. Hydria s Signatur	J. A	perk							

**ORIGINAL** 

			1 - For State Registrar	State of Maryland /	•	Health and M	_	_	10000
					Certificate of	Death	2. Date of Deat	g. No. L. UU L.	42200
	Physici	an	1. Decedent's Name (First, Middle, Last	) Ouc			Month	Day Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give	street and number)	4h City Town o	or Location of Death	12	4c. County of Death	20:404
	Examir	ier		ing + Rehab	Snow	4:11 m	1.	Worcest	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last b		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	plece (State or Foreign
	Director		232 78-8111	M 288 74	Yrs.	TIOUIS WIII.	3-17-3	30	KY
	and		Usuat Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	Maryl f ehc	ō	MD Worces	ter S	Snow Hill				1 XYes 2 □ No
	r 288	Director	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Cou	intry?
	filed within 72 hours after death with the Maryland hygiene. ther than "natural", or items 23a or 28a-f ehow ther than medical Examina must be notified at	a D	101 Division St.	•	218	63		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 👿 Divorced	1	1 □ Yes 2 <b>X</b> No	Specify:		Specify: W	nite
21215-0036	tural stural	edt	15. Decedent's Edu		a. Decedent's Usual Occup	pation		16b. Kind of Business/Ir	ndustry
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	giene giene er tha	Completed by	8	Obligo (1 401 01)	Seamstress	,		Sewing	
2	be filed Ital Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			
Maryland	should nd Men marke umaric	<b>T</b>	Harley Edward				Mae Led		
ā	C1 00 = =		19a. Informant's Name/Relationship (T)	/pe, Print) 19	b. Mailing Address (Street				o Code)
	1 and 2 Health tem 27	1	Rita Campbell 20a. Method of Disposition	20b. Place	101 Division of Disposition (Name of			AD 21863 20c. Location - City or To	own, State
Baltimore,	Pages nent of int; If it		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	removal from State	ery, crematory or other pla Henlopen_Cr	114/4	1/04	Frankford	DE
	permit. Pag Department Important; I eny injury o		21. Signature of Funeral Service Licens	The second secon					
ä	Depa Impo eny ii		Tara Leeling	1 Maskette	108 Willia	ine Bu m St. Be	irbage F rlin. MD	uneral Hom	ne
\$	1 100		23a. Pert1. Ententhe disease, or composhock, or heart failure. Listophy of	ications that caused the death. Do	not enter the mode of	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Enl Stage	alshes	mees	Dames	tea	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons tuence	e of):		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-
ķ	LAMITIME	ايا	Sequentially list conditions,	b. Due to (or as a consequence	a of h				
	ted	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	5 01).				
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	C	9 of);				
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	call		d					-
89	tificat ng phy as th	m-print)							
Вох	th cer tendir r use	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal deat	th 3 Ectopic pregnance	v		23d. Date of deliv	
Е	he att	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (specify) _	<u>,                                      </u>		Month	Day Year
P.O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if		Part II Other significant conditions co	ntributing to death but not regulting	in the underlying cause an	van in Part I	23a Did tob	acco use contribute to t	he cause of death?
ds,	he law requires tha e has been signed l ige 2 should be det	Completed by	Availer Des		0 0 10.	letus			bably 4 Unknown
Vital Records,	v requ	ete	21.2016	2.00			24a. Was ar	24h Wore auto	opsy findings available
Re	The lar	дшо	Differ of alger	our m			autopsy perform	prior to co led? death?	impletion of cause of
ta		a)	25. Was case referred to medical			26. Place of Deat	1 Yes 2		2 <b>/5</b> No
	y sign	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA	200	The second	nce 6 □Other (Special	fy)
n of	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury 28b. (Month, Day Year)	Time of 28c. Injur	rv at	28d. Describe ho		
Division	eath. or: Al	Certification;	2 Accident investigation 3 Suicide 6 Could not be		M 1 🗆	Yes 2 □No			
$\frac{2}{2}$	or Atl fter d Sirect in by	Ţ,	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Str City or Town,	eet and Number or Run State)	al Route Number,
_	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge	ne death occurred at the to	me date and place	and due to the on	use(s) and manner on a	stated
	24 hose Fun	edical	(Check only 2 Medical Exemi	ner: On the basis of examination a and manner stated.	and/or investigation, in my o	opinion, death occur	red at the time, da	te and place, and due t	o the cause(s)
	To the within 2 To the complete	Me	29b. Signat of and title of certifier	0 0	29c. Licens			d. Date signed (Month,	Day, Year)
			Megow h	Bellow	20 D2	9505	1	2-20-	04
7	11 11		O. Name and ddress of person who ca						
1	17,4		GREGORIO M.B	ELLOSO, M.D.	5302 CHINGB	ERRY DR	SALIS	BURY, MI	21801
1 12	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Sociel				

Division of Vital Records, P.O. Box 68760,

		Please	Chata of Mandana				-	_	le.
		For State	State of Maryland		artment of H tificate of I		_	7111	71, 1,2267
6		Registrer  1. Decedent's Name (First, Middle, Las	<i>(</i> )	Cer	lilicate of t		2. Date of Dea	eg. No. C	3. Time of Death
Physicia /Medic	al	Helen	Mildred		Campbel	1 ]	Decemb	ev 19 20	3:35AM
Examin	er	4a, Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	0	4c. County of	merset
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la	st birthday)	If Under 1 Year		8. Date of Birth (Month, Day	9	9. Birthplace (State or Foreign Country)
Director		216-14-2928	□ M 2)X F 84	Yrs.	Months Days	Hours Min.	Month, Day 09-27-1		(aryland
p .		Usual Residence of Decedent  10a. State 10b. County	100 City	Town or Lo	cation				10d. Inside City Limits
laryla shoved	5				cation				1 ☐ Yes 2√2 No
with the Maryland a or 28a-1 show be notified at	Director	MD Somerse  10e. Street and Number	E E	den	10f. Zip Code		] 1	0g. Citizen of Wh	
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-1 show ant. It wedical Examiner must be notified at		31808 Flower Hill	Church Road		218	22		USA	
death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	ispanic Origin? (Spec n, Mexican, Puerto R	city Yes or No-		American Indian, White, etc.
ours after death w ral', or Items 23a Examinat must	y Fu	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		1 ☐ Yes 2 No	Specify:		Specify:	
hours tural',	g p	3 ⊠Widowed 4 □ Divorced	Year or Dates:		dent's Usual Occupa	ation	1	16b. Kind of Busin	White
in 72 n "na'r	Completed by	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	kind of work done of DO NOT use retired	during most of workin ()	g	TOD. KING OF BUSIN	ilosa/muusii y
d with giene.	mo:	Elementary/Secondary (0-12)	College (1-4or 5+) none	Se	amstress			Shirt Fa	ctory
be file ntal Hyg ad othe event,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
should b ind Ment s marked umatic e	2	Elijah Baker				Berdie M			
12 sh hand 7 is m		19a. Informant's Name/Relationship (7				and Number or Rural			
permit. Pages 1 and 2 should be filled within 72 hours Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; any injury or other traumatic event. Its Medical Exa once.	3	Mary Ann Layfield 20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of	dge Road,		SS Anne, 20c. Location - Ci	
Pages nent of I ant: If it		Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	•	natory or other place				Control Control
nit. P artme ortan injur	1	21 Signature of Funeral Service Licen	ALL	22	netery I. Name and Addres	ss of Facility	2-2004	llen. Na	aryland
permit. Depart Import any in	1	most New	Ma A M00295			eral Home	Prince	acc Anne	, MD 21853
		a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications/bat caused the death.	. Do not ent	er the mode of dyin	g, such as cardiac or	respiratory arr	est,	Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):					
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led nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence or,					
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te be executed ysician and le burial-transit	call		d						
rtifical ng phy as th	Medi	IF FEMALE:							
leath certificate I attending physi of for use as the t	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3□	Ectopic pregnancy			23d. Date of Month	
the a	vslcl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5□	Other (specify)				
or Attending Physician: The law requires that the death certificate birector: Atter this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did to	pacco use contribu	ute to the cause of death?
uires sign	d b						1 □ Y	s 2 No 3	☐ Probably 4 ☐Unknown
w req	lete						24a. Wasa	n 24b. We	ere autopsy findings available
The lav te has	Completed						autops perform	ned? dea	or to completion of cause of ath?  Yes 2 No
Physician: The la r this certificate has ral director, page 2	BeC	25. Was case referred to medical			-	26. Place of Death			
hysic his ce I direx	10	examiner? 1 □ Yes 2 □ No		R/Outpatier		4 / Nursing Hom		ence 6 Other	
ing P	on:	27. Man r of Death 1 ∠Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Worl	k?	8d. Describe he	ow injury occurred	
ttend death stor: /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ne farm str		Yes 2 □ No	8f Location (S	reet and Number	or Rural Route Number,
al or Attending Phy i after death. I Director: After this d in by the funeral d	Certification:	4  Homicide determined	building, etc. (Specify,		eet, factory, office	-	City or Town		or regar results resident
spita nours neral / fillec			ysician: To the best of my know						
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medicel Exemone)	niner: On the basis of examinati and manner stated.	on and/or in	vestigation, in my o	pinion, death occurre	d at the time, d	ate and place, and	due to the cause(s)
To the vithin to the comp	ž	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed (i	Month, Day, Year)
		Nuleur			3	47094		12 - 3	21-2004
		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)	2	< her		45BULY MY
		31. Date filed (Month, Day, Year)	NATES + N 32. Registrar's Signat	1415	south	1/10/2/00	5 rea	1 3/	4/1007
Sta Registr		DEC 2 3	LUU4 flower.	J. A	perle				

			State of Maryland	i / Depa		of H	ealth an		ental Hygie	ene	nnı.	1.0	200
			Registrar  1. Decedent's Name (First, Middle, Last)		incare	01 2			Heg 2. Date of Death	, No. 🛵	004	3. Time of	Death C
	Physicia		EUGENE PAYTON CUNNINGHAM					D	Month ECEMBER	Day 17.	Year 2004	2:00	$\mathbf{P}^M$
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, T	Town, or	Location of D				inty of Death	2.00	
			LAYHILL CENTER		ROCK		LE			MONT	GOMER	Y	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la		If Under 1 Months	1 Year Days	Hours !	Min.	B. Date of Birth (Month, Day, Y	ear)	9. Birth	olace (State or ntry)	Foreign
L.	Director		250-12-5547 82 Usual Residence of Decedent	2 Yrs.				JA	PRIL 3,	1922	MARY	LAND	
	yland 10W			Town or Lo	cation							10d. Inside Cit	y Limits
	Man Barfah	tor	MARYLAND MONTGOMERY SILV	ER SPR	ING							1 🗌 Yes	2 <b>X</b> ] No
	or 28.	Jirec	10e. Street and Number		10f. Zip (	Code			100	g. Citizen	of What Cou	ntry?	
	ath w	rai	1913 MERRIFIELDS DRIVE			906				U.S.			
	er de Items	Funerai Director	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S Armed Forces?  1 □ Never Married 2 □ Married	. 13. V	Vas Decede Yes, sp <i>ec</i> i	ent of His ify Cubar	spanic Origin n, Mexican, P	1? (Spec Puerto R	ify Yes or No- ican, etc.)		Race - Ameri Black, White,		
36	urs af	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1938—	76	☐ Yes 2	🛚 No	Specify:			Spe	ocify: WH	ITE	
Maryland 21215-0036	be ilied within 72 hours after death with the Maryland ital Hygiene. Indother than "natural", or Items 23e or 28e-f show evant, the Medical Examination must be notified at evant, the Medical Examination must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a Deced	ent's Usual	Occupa	ition uring most of	f working	16	Sb. Kind o	f Business/In	dustry	
21	within ene.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use	e retired)	)	working	<b>'</b>				
2	e filed within al Hygiene. I other than '		8 17. Father's Name (First, Middle, Last)	MILITA	ARY PI			Nomo	First, Middle, Ma	idon Cun	MILIT	ARY	
anc	d be fintal h	Be c	ROBERT E. JEWELL							liueri Suri	rame)		
2	should by nd Menta markad imetic a	ို	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address				C/MERCER Route Number, (	City or To	wn, State, Zit	Code)	
	alth al		MICHAEL CUNNINGHAM/SON	1913 N	IERRIE	FIEL	DS DRI	VE,	SILVER	SPRII	NG, MD	20906	
ore,	es 1 and 2 should b of Health and Ments fitem 27 is markad r other traumetic e		20a. Method of Disposition 20b. Pla	nce of Dispos	sition (Nam-	e of		Da			on - City or To		
ij	Page ment the man to t		1 ☐ Burial 2 【XCremation 3 【XRemoval from State \ '4 ☐ Donation 5 ☐ Other (Specify) NATIO	ONAL C	REMAT	ORY	12,	/23/	2004 FA	ALLS	CHURCE	H, VIRG	INIA
Baltimore,	permit. Pages 1 Department of H Important: If its eny injury or ot once.		21. Signature of Funeral Service Licensee	DAN	IZANSK	(Y–G	s of Facility OLDBER	G ME	MORIAL (	CHAPI	ELS, I	NC.	
			23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not ente	er the mode	of dying	, such as car	rdiac or	respiratory arres	t,		Approximate Interval Betw	/een
	Physician	Ė	Immediate Cause (Final disease or condition PNEUMONIA									Onset and D	eath
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oʻ	be executed sician and burial-transit		resulting in death) Last Due to (or as a conseque	ence of):									
8760,	a × a	Jicai	d										
x 68	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnan	CV CV									
Вох	atten for us	cian	in the past 12 months?	teath 3	Ectopic pre Other (spe						Date of delive Month	-	ear
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ري ت	The law requires that the site has been signed by the sage 2 should be detache	by P	Part II. Other significant conditions contributing to death but not result	ting in the un	derlying ca	use give	n in Part I.		23e. Did toba	cco use c	ontribute to ti	ne cause of de	ath?
ord	v require been sig should b	ted t	DEMENTIA						1 🗆 Yes	2 🗆 No	3 Prob	ably 4∭∏Ur	nknown
Records,	e law n has be je 2 sh	Completed							24a. Was an autopsy		b. Were auto	psy findings a mpletion of ca	vailable use of
= =		Con							performe 1 ☐ Yes 21		death?	2 🗆 No	
Vital	Physician: T this certificat ral director, pr	Be	25. Was case referred to medical examiner?  Hospital:			Othe			Check only one)				
of		); To	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	R/Outpatient 28b. Time of	-	c. Injury	at AM Nursii	-	e 5 Residence			y)	
ion	Attanding Phy r death. actor: After thi by the funeral c	atior	1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	М	Work	.? ′es 2⊟No						
Division	l or Attano after death Diractor: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory,	office	~	28	f. Location (Stree City or Town,		m <i>ber or Rur</i> a	l Route Numb	er,
ā	Hospital or A 24 hours after Funaral Dira tely filled in bj												
	To tha Hospital or Al Within 24 hours after C To tha Funaral Dirac completely filled in by	edicai	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)	ledge, death on and/or inv	occurred a estigation, i	t the tim- in my op	e, date and p inion, death o	occurred	d due to the caus at the time, date	se(s) and and plac	manner as s e, and due to	tated. o the cause(s)	
	To tha I within 2. To tha I complet	Me	29b. Signature and title of certifier		29c.	License	number		29d	. Date sig	ned (Month,	Day, Year)	
	. 1		> Mullerello	ny	) D:	3826	2		DE	СЕМВ	ER 20,	2004	
	4		30. Name and address of person who completed cause of death (Item 2										
			A. MENDHIRATTA, M.D., 2401 RESE  31. Date filed (Month, Day, Year)  32. Pegistrar's Signatu	ARCH :	BLVD.	#33	O, ROC	CKVI	LLE, MD	2085	0		
	Sta Registr		DEC 21 2004 America	9	Spa	His							

		,	For State Registrar	State	of Maryla	and / Depa <i>Ce</i>	artment rtificate			and Me	ental H		4 3 6 4 6	) 4	422	69
	District		Decedent's Name (First, Middle,	Last)							2. Date of I		Day	Year	3. Time of	Death
	Physici: /Medic		Madge Louise Cr	ouch							Dec.	10	2004		10:25	Рм
	Examin	er	4a. Facility Name (If not institution,		mber)		4b. City, To			f Death			4c. County			
			Suburban Hospit	al 6. Sex	7 4== //=	en fant hieth daw	Beth If Under 1		a. If Under 2	24 Wrs	0. D	21.05	Monte			
П	Funeral Director		5. Social Security Number 579 • 44 • 5259	1 M 2 M F	7. Age (III y	rs. last birthday)		Days	Hours	Min.	8. Date of E (Month, I Sept. 2	Day, Y	ear)	9. Birth	place (State of ntry)Nort olina	h Foreign
	ъ		Usual Residence of Decedent								sept.2	- 1 , .		Ual	OLLIIa	
	anylan show	_	10a. State 10b. County			City, Town or Lo	cation								10d. Inside Cit	
	he Ma	ecto	MD Montg	omery	Ве	ethesda	1				····				1 🛣 Yes	2   No
	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Modical Examinar must be invilled at	by Funeral Director	10e. Street and Number 5801 Rossmore D	rive			10f. Zip C		20814			10g	Citizen of N	What Cou	ntry?	
	death ms 23	nera	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Deceder If Yes, specify	nt of His	spanic Orig	jin? (Spe	cify Yes or I	No-			can Indian,	
ဖွ	or ita	Fur	1 ☐ Never Married 2 ☐ Marrie	If Voc Ci	2 🗆 No		if Yes, specify 1 ☐ Yes 2 ☑			, Puerto F	Rican, etc.)			ck, White,		
003	ural',	d b	3 ₩ Widowed 4 Divorced	Year or E	Dates: 194	3-1975								Whi		
15	n 72 ł "nat	ete	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece (Give	dent's Usual ( kind of work DO NOT use	Dccupa done di mtimd)	tion uring most	of workin	ng	16	b. Kind of B	usiness/Ir	dustry	
21215-0036	withi	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		eputy I					1	edera	.1 Go	vernmen	nt
פָּ	e filec al Hyg otha vant,	Be C	17. Father's Name (First, Middle, L	ast)							(First, Midd			ne)		
ylaı	ould b Menta arkad	To	Amos C. Crouch								ne Gri					
, Maryland	and 2 shi raith and n 27 is m ar traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z  150 Krumville Road, Olivebridge, NY 124  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z  159 Krumville Road, Olivebridge, NY 124  20c. Location - City or Town, State, Z  159 Krumville Road, Olivebridge, NY 124  20c. Location - City or Town, State, Z  20d. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Dec. 23, 2004 Alexandria,													
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or itams 23a or 28a-f show any injury or othar traumatic evant, the Medical Examinar must be mailted at once.															
Balti	permit. Departm Importa any inju		21. Signature une Service L				Name and							ns I 016	nc.	
×			23a Part1. Enter the disease, or o	complications that	caused the de										Approximate	
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition												Interval Betw Onset and D	eath
	/Medical Examiner		resulting in death)	a. <u>Uros</u> e Due to	(or as a cons	sequence of):									6 years	3
	Examiner	_	Sequentially list conditions,	b	/											
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying	Due to	(or as a cons	equence or):										
Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to	(or as a cons	equence of):										
8760,	ysicia ysicia	dicai		d												
9	rtifica ng ph as th	Medi	IF FEMALE:													
Вох	death certific e attending p ed for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		ointh 2 ☐ Fi	etal death 3	Ectopic preg							te of deliv	-	ear
0	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregi 9□Unkn	nant at time o own	fdeath 5[	] Other (spec	ify)						*****	22,	-
<u>α</u>	law requires that the de as been signed by the a 2 should be detached f	y Ph	Part II. Other significant condition	is contributing to d	eath but not r	resulting in the u	nderlying cau	se givei	n in Part I.		23e. Dio	d tobac	co use cont	ribute lo t	he cause of de	eath?
rds	quires n sigr uld be	d by	Chronic Atria	l Fibrila	tion						1	Yes	2 🖾 No	3 🗆 Prot	oably 4 U	nknown
000	aw requir as been si 2 should	Completed	Arteriosclero	tic Heart	Disea	ase					24a. Wa		24b. \	Were auto	psy findings a	vailable
Re	he h	mo										topsy rformed 2x	1?	orior to co death? I 🗆 Yes	mpletion of ca 2□ No	use of
ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only					
) t	Physician: rthis certific ral director,	P	1 ☐ Yes 2 2 No			☐ ER/Outpatier		Other	4 🗀 1401		ne 5□Re				(y)	
Division of Vital Records,	ding F	tion:	27. Manner of Death 1 X Natural 5 ☐ Pending		of Injury th, Day Year,	28b. Time o Injury	M 280	Work:	at ? 'es 2 □ N		8d. Describe	e how	injury occuri	ed		
/isi	Attang death ctor: y the	ficat	2 Accident investigation of Could not determine the could not be could not determine the could not be could n	ot be 28e. Place	of Injury - A	t home, farm, str			03 2 01		8f. Location	(Stree	t and Numb	er or Rura	al Route Numb	er,
ă	tal or Attanding Physician: Ts after death. al Diractor: After this certificat ed in by the funeral director, p	Certification:	4 Homicide	build	ing, etc. (Spe	ecify)					City or T	own, S	State)			
	To the Hospital or Attanding within 24 hours after death.  To tha Funeral Diractor: After completely filled in by the fune.	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the xaminer: On the b and man	e best of my k asis of exam ner stated.	nowledge, deat ination and/or in	occurred at vestigation, in	the time my opi	e, date and inion, deat	d place, ar h occurre	nd due to th d at the time	e caus e, date	e(s) and ma and place,	inner as s and due to	tated, the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier		4	2	29c. l	icense	number			29d.	Date signe	d (Month,	Day, Year)	
			•	reuva	/ M	-D.	D	3655	52			Dec	cember	11,	2004	
	40		30. Name and address of person v					_	,		MD 3	005	2			
	-0-		Pankaj Talwar, I			nonston	Drive;	Ro	ckvil	LIE,	MD 2	085				
	Sta Registr			2004	d gistrar's Sig	B	Spo	in								

Madge L Crouch

	1 - State Registrar  1. Decedent's Name (First, Midde	le, Last)	C	ertificate of	Death	2. Date of Dea		(004	3. Time of De
cian	Allie Fiffeda	Carr				Month Decembe	r 17,	Year 2004	8:20
lica ine	A P TO ALL THE ME THE STREET	n, give street and number		4b. City, Town, o	r Location of Deat	h		ounty of Death	
	Genesis Elder	Care		Severna	Park		I	Anne Ar	undel
al	5. Social Security Number		ge (In yrs. last birthda	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year)	9. Birth	place (State or Funtry)
	230-48-8400	1□M 2√□F	85 Yrs.	. Months Days		May 1,	1919		nada
	Usual Residence of Decedent  10a. State 10b. Count	,	10c. City, Town or	r Location					10d. Inside City
2			i doi: dily, i dilli di	Location					1 Tes 2
To Be Completed by Eineral Director	Maryland Anno	e Arundel	Croft	10f. Zip Code			Na Citiza	n of What Cou	intry?
Ĉ	2303 M	Davi			i				,
Firmaral	2303 Montauk	12. Was Decedent	t Ever in U.S. 1	21114 3. Was Decedent of H If Yes, specify Cuba		Specify Yes or No-		SA . Race - Amer	ican Indian,
H	1 ☐ Never Married 2 ☐ Ma	Armed Forces' rried 1 ☐ Yes 2 ☐	? No			to Rican, etc.)		Black, White	
ž	3 XWidowed 4 □ Divorce	If Yes, Give		1 ☐ Yes <b>¾</b> IX No	Specify:		S	<sub>Decify:</sub> Whi	te
Completed	15. Decede	nt's Education	16a. De	ecedent's Usual Occup	ation	rking	16b. Kind	of Business/Ir	ndustry
200	Elementary/Secondary (0-12)	College (1-4or	lite	e. DO NOT use retired	d)	ixing			
2	11		Ca	feteria Wo	rker		Fo	ood Ser	vice
Bol	17. Father's Name (First, Middle				18. Mother's Nar	me (First, Middle,	Maiden Su	umame)	
3	unknown Hop	kins			Maria	Unknown			
	19a. Informant's Name/Relation	ship (Type, Print)	19b. Ma	ailing Address (Street	and Number or Ru	urai Route Numbe	r, City or T	own, State, Zi	ip Code)
	Barbara A. Sc	afone/Daught		3 Montauk					
	20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation	3 Removal from State	20b. Place of Dis	sposition (Name of crematory or other plac	Dece	mber 30,	20c. Loca	tion - City or T	own, State
	`4 □Donation 5 □ Other (		Arlingt	on Nationa			Arlir	ngton,	Virginia
	21. Signature of Funeral Service	Licensee	ľ	Francis Addre	ss ct5°fTins	Funeral	Home	e Inc	
	1 Cober	- Kams	ey	500 Univer	sity Blv	d, W, Sı	lver	Spring	, MD 20
ı	23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that cause tonly one cause on each	d the John Do not line.	enter the mode of dyir	ng, such as cardiad	or respiratory arr	est,		Approximate Interval Betwe
ı	Immediate Cause (Final disease or condition	Sersis							Onset and Dea
	resulting in death)	a	s a consequence of):						
	Sequentially list conditions	Atrial	Fibrilla	tion					
nor	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2	s a consequence of):						
Fyamina	Cause (Disease or injury that initiated events resulting in death) Last	Syncop			· · · · · · · · · · · · · · · · · · ·	<u> </u>			
T I C		Due to (or as	s a consequence of):						
		d							
7		220 16 van autoom				-			
Madi	IF FEMALE:	23c. If yes, outcome	2 Fetal death	3 Ectopic pregnancy	/		230	<li>d. Date of delived Month</li>	rery Day Yea
ian/Madi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?			- CT OH / /6-1					
velcian/Madi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 Other (specify)					the cause of deal
Dhyeldian/Madic		4□Pregnant a 9□Unknown			en in Part I.	23e. Did to	bacco use	contribute to	
2	Part II. Other significant condit	4□Pregnant a 9□Unknown			en in Part I.			contribute to	
2	Part II. Other significant condit	4□Pregnant a 9□Unknown			en in Part I.	1 🗆 Y	es 2 🗆 I	No 3□Pro	bably 4XXInk
3	Part II. Other significant condit	4□Pregnant a 9□Unknown			en in Part I.	1 □ Y	es 2 🗆 I	No 3 Pro	bably 4x1x1Jnk
Completed by	Palt II. Other significant condition	4 ☐ Pregnant a 9 ☐ Unknown  ions contributing to death			en in Part !.	1 □ Y	es 2 🗆 I	No 3 ☐ Pro	opsy findings ava ompletion of caus
Re Completed by	25. Was case referred to medic examiner?	ions contributing to death	but not resulting in the	e underlying cause giv	26. Place of Dec	1 Yes	es 2 1 in 2 in 3 in 3 in 3 in 3 in 3 in 3 in 3	No 3 Pro  24b. Were autroprior to codeath?  1 Yes	opsy findings ava ompletion of caus
To Be Completed by	25. Was case referred to medic examiner?	at Hospital:	but not resulting in the	e underlying cause giv	26. Place of Dea	24a. Was a autope performed to the control of the c	es 2 1 1 2 2 3 4 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	No 3 Pro  24b. Were aut prior to co death? 1 Yes	opsy findings ava ompletion of caus
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To Be Completed by	25. Was case referred to medic examiner?	al Hospital:  28a. Date of Injury (Month, D. Input Inp	but not resulting in the	e underlying cause give	26. Place of Dea	24a. Was a autops perfor 1 yes ath (Check only or dome 5 Residual 28d. Describe he	es 2 1	No 3 Pro  24b. Were aut prior to cc death? 1 Yes  Other (Speci	opsy findings ava ompletion of caus 2 No
To Be Completed by	25. Was case referred to medic examiner?	al Hospital: 1   Inpat   Ing tigation In to be mined	but not resulting in the	e underlying cause give	26. Place of Dea ier: 4X Nursing H y 4?	24a. Was a autops perfor 1 yes ath (Check only or dome 5 Residual 28d. Describe he	es 2 1 1 2 2 2 2 No 2 2 2 2 No 2 2 2 2 No 2 2 2 2	No 3 Pro  24b. Were aut prior to cc death? 1 Yes  Other (Speci	opsy findings ava ompletion of caus
Certification: To Be Completed by	25. Was case referred to medic examiner?  1  Yes 2  No  27. Manner of Death 2  Accident inves 3  Suicide 6  Coulc 4  Homicide deter	al Hospital: 1 Inpat ing tigation I not be mined Pregnant a 9 Unknown  al Hospital: 1 Inpat (Month, D. 10 to be building, a	but not resulting in the	e underlying cause give	26. Place of Dea ner: 4X⊡ Nursing H yar k? Yes 2 □ No	24a. Was a autop performent of the control of the c	in prod?  sy y 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No 3 Pro  24b. Were autorior to condeath?  1 Yes  Other (Special Control of C	opsy findings ava ompletion of caus 2 No
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To Be Completed by	25. Was case referred to medic examiner?  1  Yes 2  No  27. Manner of Death  1  Natural 5  Pend inves  3  Suicide 6  Coulc deter  29a. Certifier 1  Certify (Check only one)	at Hospital: 1 Inpat 28a. Date of Infulding digation Innote mined 28e. Place of the building, a large representation of the basis and manner's	but not resulting in the	e underlying cause give	26. Place of Dea er: 4X□ Nursing H y at k? Yes 2 □ No ne, date and place pinion, death occu	24a. Was a autops perford 1 yes ath (Check only or dome 5 Reside 28d. Describe here.)  28f. Location (S. City or Town.)	in 2 2 1 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	No 3 Pro  24b. Were autiprior to codeath? 1 Yes  Other (Special Coccurred)	opsy findings ava ompletion of caus 2 No
odical Cartification: To Be Completed by	25. Was case referred to medic examiner?  1	at Hospital: 1 Inpat 28a. Date of Infuliding digation Innot be mined 28e. Place of the building, examiner: On the basis and manner's ser	but not resulting in the	e underlying cause give titient 3 DCA Other of 28c. Injury Wor M 1 cast occurred at the tire in investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation, in my cast occurred at the tire investigation.	26. Place of Dea er: 4X□ Nursing H y at k? Yes 2 □ No ne, date and place pinion, death occu	24a. Was a autops perford 1 yes ath (Check only or flome 5 Residual 28d. Describe he 28f. Location (S. City or Town) a, and due to the curred at the time, de 28f.	ause(s) anatate and places	No 3 Pro  24b. Were aut prior to cc death?  1 Yes  Other (Special coccurred)  Number or Run  and manner as a ace, and due to	opsy findings avacompletion of caus  2 No  ral Route Number  stated. to the cause(s)  Day, Year)
edical Cartification: To Be Completed by	25. Was case referred to medic examiner?  1	al Hospital: 1 Inpat 28a. Date of Injudicing digation of not be mined 28e. Place of Inbuilding, examiner: On the basis and manner ser	but not resulting in the	e underlying cause give titient 3 DCA Other of 28c. Injury M 1 street, factory, office eath occurred at the tire investigation, in my of 29c. Licens D56	26. Place of Dea er: 4X Nursing H y at k? Yes 2 □ No me, date and place pinion, death occu	24a. Was a autops perford 1 yes ath (Check only or flome 5 Residual 28d. Describe he 28f. Location (S. City or Town) a, and due to the curred at the time, de 28f.	ause(s) anatate and places	No 3 Pro  24b. Were aut prior to cc death? 1 Yes  Other (Special cocurred	opsy findings available opsy findings available of cause 2 No  all Route Number stated. The cause (s)  Day, Year)

VDEN, LOUISE 2/2-16-7489

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	Please	Type or Pri		Depa		ealth and M	lental Hygie	•	
Physicia /Medica	n	1. Decedent's Name (F		,			imouto or k		2. Date of Death Month / 2	Day Yea / 9	
Examine Funeral Director	r	ta. Facility Name (If no PN/N34/A) 5. Social Security Num 212-16-7	RegioNA ber 6. S	Medica	(In yrs. last b	irthday) Yrs.	4b. City, Town, or  SA  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10-07-19	4c. County of De 1/CO/1/(ear) 9. E	
e Maryland a-f show	Ī	Usual Residence of De 10a. State 10 MD	cedent b. County WICOM	ICO	10c. City, Tov						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinar must be notified at once.	Funeral Director	10e. Street and Number $1503 \;\; \mathrm{OLD} \;\; \mathrm{O}$ 11, Marital Status		TY ROAD  12. Was Decedent Armed Forces?	Ever in U.S.	13.	10f. Zip Code  Was Decedent of Hif Yes, specify Cuba	21804	ecify Yes or No-	J. Citizen of What  USA  14. Race - Ar  Black, W	merican Indian,
2 hours after atural, or ite	2	1 ☐ Never Married 3 🛱 Widowed 4 ☐	Divorced  Decedent's Ed	1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	No	a. Deced	1 ☐ Yes 2 ☑ No	Specify:	16	Specify:	WHITE
filed within 7: Hygiene, other than "n ent, the Med	Completed	(Specify Elementary/Seconda		College (1-4or:	5+)	life.	kind of work done of DO NOT use retired		ing a (First, Middle, Ma	BANI uden Sumame)	X
2 should be and Mental is marked o	To Be	CARL THEOD	/Relationship (	ype, Print)					HUSTON  al Route Number, ( ALISBURY		
Pages 1 and nent of Health int: If Item 27 ury or other t	-	TED D. GRA  20a. Method of Dispos  17 Burial 2 0  4 0 Donation 5 (	ition Cremation 3 [	Removal from State	20b. Place comete	of Dispo	esition (Name of matory or other place	e) i	Date 20	c. Location - City	
permit. Pages Department of Important: If it any injury or o		21. Signature of Pune 23a. Part1. Enter the	disease, or con	Jeur Jeur Jeur Jeur Jeur Jeur Jeur Jeur	Me death. Do	70	)5 EAST M	AIN STREE		URY,MARYI	LAND 21804 Approximate
Physician /Medical Examiner	miner	shock, or heart te Immediate Cause (Fin disease or condition resulting in death)  Sequentially list condit if any, loading to imme- cause. Enter Underlyi Cause (Disease or inju- that initiated events	al C	. GANG		of): US	CK STOM	NACH BST RU	CTION		Interval Between Onset and Death Aday  Aday  Aday
Paris Paris	al Ex	resulting in death) Las	' L	Due to (or as	a consequence	of):					0
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	23b. Was decedent pr in the past 12 mg 1  Yes 2 N 9  Unknown	nths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
he law requires tha a has been signed tge 2 should be det	٥	Part II. Other significa	nt conditions o	ontributing to death t	out not resulting	in the u	nderlying cause give	en in Part I.	1 ☐ Yes	2 No 3	Probably 4 Unknown
stcian: The law certificate has I	Be Completed	25. Was case referred examiner?	to medical					26. Place of Deat	24a. Was an autopsy performs 1 Yes 22	prior	
hys his	ertification: To i	1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident	5 Pending investigation 6 Could not b		lry ly Year) 28b.	Time of Injury	Worl M 1□	4 Linuising no	me 5 Resident	injury occurred	pecify)  Rural Route Number,
tospital or Al hours after of uneral Direction by	edical Certif	4 Homicide  29a. Certifier 1		building, e ysicien: To the best	of my knowledg	ge, deat			City or Town, and due to the cau	State) se(s) and manner	as stated.
To the t within 24 To the F complete	Medi	29b. Signature and fill  30. Name and address	e of certifier	and manner st	ated.		29c. Licenso	9 number /56 7	290	1. Date signed (Mo	
Stat Registra		NICHOLAS 31. Date filed (Month,	5.	DUDAS 32. Regist	145 E	E. C	ARLOW S	T. SALI	SBURY	MD O	4801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** DEShields **LRANK** + REDERICK December 17, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL Medical Miconico 3AU/364M TENIASULA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03-03-3 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days (05 Yrs. 214-36-7261 108M 2□F Director MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene at the state of 1884 of 1884 of 1894 of 1 FRuitland # MDCompleted by Funeral Director Wicomico 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 28 No 21826 6 DRIVE 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 252 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 2 No Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CROWN CORK & Seal Lift-OPErator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be USCAR DESHIELAS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DEShields Fruitland MD & Co. 20c. Location - City or Town, State B MD 21826 trivend Linda Drive Apt 2 NoRma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages nent of h 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. ST. James a.N.C. Cemetus 12-23-4 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home 130639 NO 21853 811 Hampden 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) physician s the burial Box 68760. attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 rmeg? 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ✓ Yes 2 ☐ No 3Z DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide within 24 hours e 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 29168 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1346 Robert Allen Md. St. Salisbury Md. 21804 S. DIVISION 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DEC 2-3 2004

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death December 17 2004 **Physician** Bertha Estelle Dietzway 6:10 am /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Westminster Nursing and Convalescent Center Westminster Carroll 8. Date of Birth Feb 18, Year 922 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs 213-12-8774 1□ M 25 F 82 MD Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nant of Health and Mental Hygiena. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No **Funeral Director** MD Carroll Westminster or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Road 21157 USA Herns 23a 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married ō Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Sunpapers Carrier Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental important: if item 27 is marked or any Injury or other treumatic eve Mary Fritz Truman Fogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dorothy Boone/Godchild 3295 Oak Street Manchester, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenwood Cemetery 12/20/2004 New Windsor, MD 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): by Physician/Medical Examiner sata has been signed by the attanding physician and page 2 should be datached for usa as the bunal-transit Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e conseque CI 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 X Yee 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No this certificata 1 TYUE 2 VINU After this certifical funeral diractor, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔼 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours aftar death.

To the Funerel Director: Af completaly filled in by the fu death 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 X Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as steted. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04 address of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 0 2004

32. Registrar's Signature

	·	_	1 - For State Registrar		Marylan		artmen rtificate			and M		Reg. No.	) 4 1	2275		
	Physici /Medic	ai	Decedent's Name (First, Middle,     Frederick G      4a. Fecility Name (If not institution,	lenn Fre	eburne		4h City	Tour or	Location o	of Dogsth	2. Date of De Month Decemb	per 18,	Year 2004 nty of Death	3. Time of Death 6:40P. M		
	Examir	ier	3122 Gracefield	Rd., #CT6	808	lo at hirthday		ilve	r Spr	ring	9 Date of Bird	Mor	ntgomer			
	Funeral Director		5. Social Security Number  467–54–0536  Usual Residence of Decedent	1 □ M 2 □ F	7. Age (In yrs.	83 Yrs.	Months	Days	Hours	Min.	8. Date of Birl (Month, Da April 2	24, 1921	I Kans	place (State or Foreign htry) Sas		
	a-f show	ctor	10a. State 10b. County Maryland Montgo	mery	10c. Cit	y, Town or Lo Silve		ing					1	0d. Inside City Limits		
	th with th	Funeral Director	10e. Street and Number 3122 Gracefield	Road, #C	T608		10f. Zip	Code 904					of What Cour ed Stat			
980	d within 72 hours after death with the Maryland jene. r than "natural", or itams 23a or 28a-f show the Macical Ex-cilier court be notified at	þ	11. Marital Status  1 Never Married 2 X Marrie 3 Widowed 4 Divorced		ces? 2 □ No	1	Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	Yes or No- n, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White				
21215-0036	within iene. r than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		4or 5+) 5 <b>+</b>	(Give life.	dent's Usua kind of woi DO NOT us	rk done d se retired;	luring mosi )	t of worki	ing	16b. Kind of Business/Industry  Education				
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be (		Freeburn	e				Beat	rice		icCollu	ım			
	nd 2 shi lith and 27 is m r traum		19a. Informant's Name/Relationshi Mary Margaret F			3122	Grace	efie	ld Ro	ad,		Silver	Sprin	ng, Md.2090		
Baltimore,	0 0 -		20a. Method of Disposition  1 ☐ Burial 2 ▼Cremation 3  '4 ☐ Donation 5 ☐ Other (Spe	ecify)	State Me1		itan (	rema rema		12/		Alexa		Virginia		
Bal	permit. Pag Department important: i any injury o		21. Signature of Funeral Service Li	Burgera	M	4	400 P	owdei	r Mil	⊥ Ro	Funera ad Belt	sville	P.A.	rland 20705		
	Physician /Medical Examiner physician and physician and the printi-transit the printing of the	Examiner	23a. Pert1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Mali Due to (c  Congo Due to (c  End	gnant ( gnant ( or as a conseq estive or as a conseq Stage I or as a conseq	Cardia uence of): Heart uence of): Renal I	l Arrl Failu	nythr ire						Interval Between Onset and Death		
8760,	cate be ex physician the buria	edicai E		d. Anem												
.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	I death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>						Date of delive Month	ery Day Year		
ds, P	juires that the n signed by th ild be detache	by	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying c	ause give	en in Part I.			obacco use co Yes 2 🛣 No		ne cause of death? ably 4 □Unknown		
Vital Records,	: The law requires cate has been sign ; page 2 should be	Completed									24a. Was autop perfo 1 \( \text{Yes} \)	an 24l osy rmed? 2 <b>X</b> No	prior to cor death?	psy findings available inpletion of cause of		
	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	npatient 2	ER/Outpatier	nt 3 DC	A Othe			n <i>(Check only o</i>		Other (Specifi	u)		
ion of	ding h. After fune	atlon: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident investiga	28a. Date o (Month		28b. Time o Injury		8c. Injury Work	at		28d. Describe I			7		
Division	irec lrec	Certifica	3 □ Suicide 6 □ Could no 4 □ Homicide determin	ed 286. Flace buildir	of Injury - At hing, etc. (Specif	(y)					City or Tov	vn, State)		l Route Number,		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier X Certifying (Check only 2 ☐ Medicel E	Physician: To the xeminer: On the ba and mann	isis of examina	owledge, deat ation and/or in	h occurred vestigation,	at the tim in my op	e, date <i>a</i> ndinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)		
)	N V Complete	Σ	29b. Signature and title of certifier	Setlas	Has	eget.		. License 00052				29d. Date sig Decemb	ned (Month, loer 20)	* * * * * * * * * * * * * * * * * * * *		
	( 0		30. Name and address of person w Chandrasekhar Ko	ho <i>co</i> mpleted cause <b>Drapati,</b> N	e of death (Item	n 23a) (Type, 107 Han	Print)	Park	way,	#B (	reenbe]	lt, Mar	cyland	20770		
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 21	2004 32. Rg	gistrar's Signa	dature 9		ack				-				

			riease	State of Marylan				-	•	
			For State Registrar	Oldio of Marylan		ficate of D			Reg. NO. 004	42276
			Decedent's Name (First, Middle, La	ist)				2. Date of Dea	ith	3. Time of Death
	Physici /Medic		George	Austin	Godwi	n Jr		December.	Day Year 16 2004	01:35 M
	Examin		4a. Facility Name (If not institution, giv	·		b. City, Town, or L	ocation of Death		4c. County of Deat	י
			Peninsula Regio				isbury		Wicomic	
- 1	Funeral		5. Social Security Number 6. S 215-20-1532	HEIM OF E		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	77				10/13/1	92/ Mary	yland
	yland		10a. State 10b. County	10c. City	, Town or Loca	tion				10d. Inside City Limits
	e Mar	ctor	Maryland Wicomio	co Sa	lisbury	•				1 ☐ Yes 2X No
	death with the Maryland ms 23e or 28a-f show roust ke nolling at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
3	s 23e	rai	4820 Meadowlark I			21804			USA	
3	ltem Item	nn-	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces?		is Decedent of His es, specify Cuban	panic Origin? (Spe , Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
920	urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Arm Year or Dates:	1 <b>y</b> 1□	]Yes 2█No	Specify:		Specify: wh	ite
5-0036	natura	Completed	15. Decedent's E	ducation	16a. Deceder	nt's Usual Occupat	ion		16b. Kind of Business/l	ndustry
200	ithin 7	nple	(Specify only highest grant   (Speci	College (1-4or 5+)			iring most of workii	ng	200	
, <u>7</u>	led w lygien her th	Cor	8	-	Mainte	nance wo			Maintenan	ce
3no	I be fi	To Be	17. Father's Name (First, Middle, Last George Austin Good				18. Mother's Name Mamie	Wats	-	
215 - 20 Maryland 2121	should a Me mark matic	ĭ	19a. Informant's Name/Relationship (		19b Mailing				r, City or Town, State, Z	in Code)
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other treumatic event, Ite Medical Examinet must be notified at any injury or other treumatic event, Ite Medical Examinet must be notified at any injury.		Dora M. Godwin/wi						ry, MD 2180	
ē,	s 1 a of Hee item othe		20a. Method of Disposition	20b. P		ion (Name of tory or other place)		ate	20c. Location - City or	
Ē	Page nent c ent: If ury or		1 ⊠Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special	Tuelliosar liotti State	sons Ce		12/20	/04	Salisbury,	MD
Baltimore,	ppartn porte iy inju		21. Signature of Funeral Service Lice				of Facility Theral Ho	_	essional As	
_	207		David H.	nompson C		Coort III	ים הם רו	_ 7 - 3 1	- NED 04004	5001401011
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter	the mode of dying,	such as cardiac o	r respiratory ar	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a cerebovas	cular a	reident	·			Onset and Death
	/Medical Examiner		<b>1</b>	Due to (or as a consequ	uence of):					
		e	Sequentially list conditions,	b. Due to for as a consecu	ienga offi					
	ate be executed nysician and he burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	C						
0	be executed Ician and burial-transit	Exc	resulting in death) Last	Due to (or as a consequ	ience of);					
8760,	ate be hysici the bu	lical		d						
89 x	leath certificat attending phy I for use as the	Physician/Med	IF FEMALE:	220 Hayon nathanna of present						
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3□Ed	ctopic pregnancy other (specify)			23d. Date of deli-	very Day Year
P.O.	that the death ed by the atte detached for	iysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	3d(ii 5 0	mier (specify)				
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ဝင္ပ	e law requ has been je 2 should	plet	CAD					24a. Was a		opsy findings available ompletion of cause of
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of	Physicien: this certific ral director,	To.	1 ☐ Yes 2 ☑ No 27. Manner of Death	The second second second	ER/Outpatient 28b. Time of		4   Nursing Hon		ence 6 Other (Spec	rfy)
- Lo	ng fter ineri	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury a Work? M 1 \(\tau\) Ye	es 2 □No	.od. Describe n	ow injury occurred	
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ă	s after	Certification:	4  Homicide determined	building, etc. (Specify	")			City or Tow	n, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director. After th completely filled in by the funeral		29a. Certifier 1 Certifying Pt	nysicien: To the best of my kno- miner: On the basis of examinat	wledge, death or	ccurred at the time	, date and place, a	nd due to the c	ause(s) and manner as	stated.
	the H nin 24 the F nplete	Medical	one)	and manner stated.						\-\(\frac{\cdot\}{\cdot\}\)
	To To	~	29b. Signature and title of certifier	1/11/2		29c. License	number	2	9d. Date signed (Month	, way, Year)
	my		John El	Willow Or	220) / = = = = =	#005	4368		12/16/04	
j	VA		30. Name and address of person who	ISILII 100 E.	Carroll S	t Salis	9368 buny MIS	21809	*	
	Sta	te	31. Date filed (Month, Day, Year) DEC 2 1 20	32. Hegistrar's Signal	ture 💪	do d	1			
E	Registr	ar	DEC 2 1 20	1U4 Jeneral	P	apour				

George A. Gollwid

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	Physici /Medio	ai	1. Decedent's Name (First, Middle, Las  4a. Facility Name (If not institution, give	Geronimo		4h City Town o	or Location of Death		Day Year	(3.2		
	Examir	ier	5, Social Security Number 6. Se	CLO HX H	IRE last birthday) 15 Yrs.	If Under 1 Year Months Days	Dillip,	8. Date of Birth (Month, Day, Yea	LUICON	hplace (State or Foreign unitry)		
	Director		Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo	ocation		13-17	1934 Pe	nnsylvania  10d. Inside City Limits		
	the Mary 28a-1 sho	Director	Maryland Wicomico	Sa Sa	lisbur	Y 10f. Zip Code		100.0	Citizen of What Co	1 X Yes 2 □ No		
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show adical Ezaminat must be notified at	Funeral Di	351 Deer's Head Ho	DSpital Road  12. Was Decedent Ever in U. Amed Forces?	S. 13.	21802	Hispanic Origin? (Sp an, Mexican, Puerto		USA  14. Race - Ame Black, White	ncan Indian,		
-0036	hours afte	þ	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced  15. Decedent's Edi	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	Specify: White				
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Maryland	nould be filed I Mental Hygi narkad othar natic evant, I	To Be C	17. Father's Name (First, Middle, Last) Vincent	Novi			Evelyn	e (First, Middle, Maid	Ken	drick		
_	d 2 st th and t7 Is n traun			on)	606 5	econd St	reet, Gal	al Route Number, City laway, New		Zip Code) 08205		
Baltimore,	Se to I		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐   4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	emetery, crei	sition (Name of matory or other place	ce)	La	Location · City or	Town, State		
	Med Department Page Department Important: Important: If any injury o gnce.		23a. Part 1. Enter the disease, or compshock, or heart failure. List only companied the control of the control	lications that caused the death	CFSP 5	Name and Addre OITOWAY OI Snow or the mode of dyir	res of Facility Funeral H Hill Roa ng, such as cardiac	ome Profes d, Salisbu	ssional Ā	ssociation		
	Examiner	Examiner	Sacus Italy set on Allors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence)	2 F		RUTU					
,09289	icate be executed physician and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a consequence)	uence of):	ENS						
.O. Box 6	death certif e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deli	ivery Day Year		
<u>α</u>	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Dther significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did tobacc		the cause of death?		
Il Records,	The ate h	Completed						24a. Was an autopsy performed?	prior to c death?	topsy findings available completion of cause of		
Vital	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatier	it 3 DOA Oth	ar.	h (Check only one)	6 □Other (Spec	cify)		
sion of	ling After fune	atlon; T	27. Manner of Death 11. Natural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe how in				
Division	in ite	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (Street City or Town, Sta		ral Route Number,		
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	(Check only 2 Medical Exam	rsician: To the best of my kno inar: On the basis of examinal and manner stated.	wledge, death tion and/or in	vestigation, in my o	pinion, death occur	red at the time, date a	ind place, and due	to the cause(s)		
	To To With		29b. Signature and title of certifier  Auc S	o. France	and the second	29c. Licens	)/4z56	29d. L	Date signed (Month	) ( Day, Year)		
	ONP		V (VOASTAZ	ompleted cause of death (Item	E	Print) Jan	les Isaac	DEFR	SAF	\$7		
	Sta Registr	1.44	DEC 2 1 20	32. Registrar's Signa	ture &	Spark	n					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege

		1 - For State Registrar	State of Maryland	•	artment of H rtificate of L		ind M		iene g. No.	04 1	+2278
Physici	an	Decedent's Name (First, Middle, Las     JOHN D GF	RESHAM					2. Date of Deat December	h Day	2004	3. Time of Death  7 13 4 M
/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location o	f Death	occi v ·		inty of Death	1.10
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Funeral		5. Social Security Number 6. Se	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth			ace (State or Foreign
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pu &		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	ncation					10	Od. Inside City Limits
shor	5				oution .						1 ☐ Yes 2 ☐ No
the M 28e-f	Director	Md Prince (	Georges La	anham	10f. Zip Code			1	On Citizen	of What Count	Λ
with (		9102 Elder Berry	Way		2070	16		'	-	S.A.	Ty:
ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23e or 28e-f show event, tre Medical Evanare must be routified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. <sup>1</sup>	Was Decedent of Hi	spanic Orig	gin? (Spe	ecify Yes or No-		Race - America	an Indian,
r Iter	F	1 Never Married 2 Married	Armed Forces?  1		If Yes, specify Cuba		, Puerto	Rican, etc.)	ł	Black, White, e	_
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IC 212		12th 17. Father's Name (First, Middle, Last)		Me	chanic	19 Mothe	r'e Name	(First, Middle, M		ivate	
Maryland 2 d 2 should be filed th and Mental Hygia 7 is marked other traumatic event, i	Be	Jesse D. Eva	า					ne Gresh		raine)	
ore, Marylanc	L <sub>O</sub>	19a. Informant's Name/Relationship (1		19b Mailir	ng Address (Street a					wn. State. Zin	Code)
Mar d 2 sho dth and traum		Carolyn White - 1			Elder Be					20706	,
Te, M 1 and 2 Health Hem 27 tem 27		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of					on - City or Tox	wn, State
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		21. Signature of Funeral Service Licen			2. Name and Addres	-	y Dage	eeman Fu	nowa I	Comri	200
Balt permit. Departr Imports eny inju	ly i	> Gendany	ruenan	ъ	.O. Box 4	116. 5					
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the Prin 24 the Prin Plete	Medical	one)	and manner stated.								
Vite to the contract of the co	2	29b. Signature and title of pertifier	110		29c. License	) Fy	Olli	1/ 1	A I	gned (Month, L	) 17 / 1
011		emojaly,	192		200	10	77	8	1//	1/00	DOLLET
43/16		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) XOCC	rec,	1 ~	Comn	ung	Ty F	COSPACIO
100	oto	31. Date filed (Month, Day, Year)	2. Registrar's Signal	ture	3/18 0	3000	LUCA	KUN)	LAI	1474, F.	11) 20 706
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		1	For State Registrar	Otato of	.viai y tai i		rtificate			a moi		eg. No.	ann.	42	279
		_	Decedent's Name (First, Middle, L	.ast)							Date of Deat	th		3. Time o	of Death
Phys	siciar edica		Barbara P. Gras	sie							Month cember	Day r 15	Year 2004	6:00	рм
Exam		4 .	a. Facility Name (If not institution, g	ive street and numi	ber)		4b. City, T	Town, or l	Location of	Death		4c.	County of Dear	th	
			Holy Cross Hos						Sprin				Montgo		
Funer				Sex 7	. Age (In yrs. i	Vre		Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	, Year)		thplace (State ountry)	or Foreign
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fier d		į '	Marital Status     1 □ Never Married 2 □ Married	Armed Ford	es? !⊠No					Puerto Rica	Yes or No- an, etc.)		Black, Whit		
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Hygle thert			12 7. Father's Name (First, Middle, La.	st)		Ноп	nemake		18. Mother	r's Name (Fi	irst, Middle, I		wn Home	<u> </u>	
VIZITION Duld be filt Mental Hy arked oth		0	Herman I. Pels	- '							W. McI				
shoul wind M	1		9a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street ar					Town, State, 2	Zip Code)	
INTE, INTELYIGING X IX ID-UUJO IS 1 and 2 should be filed within 72 hours efter death with the Marylan of Heelth and Mental Hyglene tiem 527 is marked other than "natural", or Items 23a or 28a-1 show giben 72 is marked other than "natural", or Items 23a or 28a-1 show giben 72 is marked other than "natural", or Items 23a or 28a-1 show			John E. Grassie	/Son		142	2 Woo	dman	Aven	nue. S	ilver	Spr	ing. M	2,1902	)
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			Kshama Garg,		00 но1		orth	Dr.,	Deer	wood,	MD 20	855			
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		•	For Stete Registrer	State of	f Maryland		artment of H		nd Mental H	ygienę Reg. Né	2007	42	280
	Dharaisi		1. Decedent's Name (First, Middle,	_ast)					2. Date of I	Death Da	y Year	3. Time	e of Death
	Physici /Medio		Thomas Fr	anklin (	Grimes,	Sr.					2, 2004	2	:00A M
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			Montgomery Gen				01ney			M	lontgome	ry	
	Funeral		Social Security Number 6	.Sex 1☐ <b>X</b> M 2☐ F	7. Age (In yrs. la	**	If Under 1 Year Months Days	If Under 2-		Day, Year)	Co	untry)	te or Foreign
	Director		212-10-3966		88	Yrs.			Oct.	31, 1	916 Mar	yland	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside	City Limits
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	ns 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S		Was Decedent of H	ispanic Origi	in? (Specify Yes or		14. Race - Ame	rican Indian	,
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Maryland 21215-0036	as 1 and 2 should ba for the should ba for the should be filten 27 is markad of rothar treumatic ever	70	Samuel Floy	d Grimes	3			Be	rtie Duv	a11			
ar	and and ls ma		19a. Informant's Name/Relationship		_		_		or Rural Route Nur	-			
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altimore,		1	20a. Method of Disposition 1	□Removal from		lace of Dispo emetery, cre	osition (Name of matory or other place	e)	Date	20c. L	ocation - City or	Town, State	
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П			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that cally one cause on e	aused the death ach line.	n. Do not en	ter the mode of dyin	ig, such as c	ardiac or respiratory	arrest,	,	Approxir Interval	nate Between
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	el or A s after ol Direct	Cert	4 - Homeda	Dallal	rig, etc. (Specify	'/			Only or	Own, State	5)		
	To the Hospitel or within 24 hours afte to the Funerel Director completely filled in the formulation of the		29a. Certifier Certifying	Physician: To the	best of my know	wledge, deal	h occurred at the tin	ne, date and	place, and due to the	ne cause(s	) and manner as	stated.	
	he H in 24 he Fi	Medical	one)	and manr	ner stated.	lion and/or ir	estigation, in my o	pinion, deatr	occurred at the tim	e, date and	a place, and due	to the caus	B(S)
	To the Hospitel of within 24 hours at To the Funerel D completely filled it	Σ	29b. Signature and title of certifier	2	^	~ ~	29c. Licens			29d. Da	te signed (Monti		
)			) 41-X		\ \rac{\sigma}{\sigma}	~	D3.	563	5	Dece	سلطم	22,7	004
			30. Name and address of person w	no completed caus	e of death (Item	23a) (Type	Print)						
			JOSEPH KAPLA	~, mb	18111 Pa	inu	Philip	DR	o LNE	7.	WD 2:	877	
	Sta	ate	31. Date filed (Month Car Car)		istrar's Signal		A w .						
Ŀ	Regist	rar	- D 1	1			DBAGE.						

04-08131 THERON E GREENHAWK WHM

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Glate C	VI IAIC	ii yiailu i	Department	OI I	icaitii a
			Certificate	of	Death

Physician /Medical Examiner
Euparal

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Prysician /Medical **Examiner** 

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar			Cer	tificate of l	Death		1	Reg. N	2 U	04	422	189
196	1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea			200	3. Time of	
n	Theron Edwar	d Greenhav	<b>v</b> k					DECEMBI	SR 5	18, 2	2004	2:18	3 A M
al er	4a. Facility Name (If not institution OCEANGATE WAY			E RD	4b. City, Town, or TRAPP		of Death		4	-	of Death	)	
	5. Social Security Number 217–82–1626	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 39	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h 96	3	9. Birthpla GELTI	ace (State o	or Foreign
	Usual Residence of Decedent												
_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation •						10	d. Inside C	
cto	Maryland Dorch	ester		Cambrio	ige							1 🗀 10S	2 <b>□</b> ₩0
ai Dire	10e. Street and Number 5939 Horn Poin	t Rd.			10f. Zip Code 21	.613			10g. C	itizen of \	What Count	ry?	
ner	11. Marital Status	12, Was Dece Armed Fo	edent Ever in U.	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Ori	igin? (Spe	ecify Yes or No-	-		e - America		
Be Completed by Funeral Director	1 Never Married 2 Marri 3 Widowed 4 Divorced	nied 1 ⊟Yes If Yes, Giv	2 1 N6	1	Yes 2 No	Specify:		r nouri, etc.)		Specify	v: _	White	
ted	15. Deceden	nt's Education st grade completed)		16a. Deced	lent's Usual Occup	ation	t of work	ina	16b.	Kind of B	usiness/Ind	ustry	
mple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	ified Sof	1)			Fed	leral	l Gove	ernmen	n t
ပ္သ	17. Father's Name (First, Middle,	Last)		OIG55	LITCG DOL			e (First, Middle,				Limer	10
To Be	Leonard Gre	1						a Jean l					
	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street	and Numbe	er or Rura	al Route Numbe	er, City	or Town,	State, Zip	Code)	
	Kirsten Wilhel	m Greenhav	wk/Spou	se 5939	9 Horn Po	int 1	Rd.,	Cambrid	lee.	, MD	2161	.3	
	20a. Method of Disposition		1 -	lace of Disposemetery, crem	sition (Name of natory or other place	(e)		Date	20c. l	_ocation -	City or Tov	vn, State	
	1 Burial 2 Cremation  1 Donation 5 Other (S		State		yChurchCe		ry 12	2/22/200	)4 (	Churc	ch Cre	ek. N	D.
	21. Signature of Funeral Service	Licensee											
	teres entres	red for	xuc	el.	Name and Addre Curran-Br 308 High	St.,	Cami	bridge,	MD	<sup>=</sup> , 216	513		
	23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that c	aused the deat									Approximat Interval Bet	te tween
	Immediate Cause (Final	Corny one cause on c	11.00	T 2	121							Onset and	
	disease or condition resulting in death)	a. Due to	or as a conseq	uence of):	(10)								
Jer	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conseq	uence of):									
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events												
EX	resulting in death) Last	Due to	(or as a conseq	uence of):									
cai		d											
/Medicai Examiner	IP PPAAAI F.												
Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live b	come of pregna pirth 2 Peta pant at time of down	Ideath 3□	Ectopic pregnancy Other (specify) _	,					te of deliver inth (	,	Year
F.	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the ur	nderlying cause giv	en in Part I	1.	23e. Did to	obacco	use cont	ribute to the	e cause of c	death?
ed by		•						1 🗆 🗅	/es	No	3 Proba	ıbly 4 □l	Unknown
pie								24a. Was		24b.	Were autop	sy findings	available
E								/ perfo	rmed? 2□N		death?	2 No	
BeC	25. Was case referred to medica	ı!				26. Place	e of Death	n (Check anly o					
ToB	examiner? 1 X Yes 2 ☐ No	Hospital: 1 🔲 I	Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nu	ursing Ho	me 5 Resid	dence	6X1Oth	er (Specify)	SCEN	E
2	27. Manner of Death	28a. Date	of Injury th Day Year)	28b. Time of Injury	28c. Injur Wor	y at		28d. Describe h					
atlo	1 Natural 5 Pendir 2 Accident investi	igation   Z   19	Elcy	1:57		Yes 25	(No	Drivera	In	The Inv	cliredin	cellis	166
=	3 Suicide 6 Could	ninged 200. Flace	of Injury - At he	ome, farm, str	eet, factory, office			28f. Location (S	Street a	nd Numb		Route Num	nber,
ert	4 E Holliedo	Duildi	ing, etc. (Specin	STVR	o <del>d</del>		(	a Tempo CKLE				E, mo	
Medical Certification:	29a. Certifier 1 Certifyin (Check only one)	ng Physician: To the Examiner: On the b	best of my kno asis of examina ner stated.	wiedge, death	occurred at the tir	ne, date ar pinion, dea	nd place,	and due to the	cause(	s) and ma	anner as sta	ated.	s)
Me	29b. Signature and title of sertific		1/		29c. Licens				29d. D	ate signe	d (Month, D	Jay, Year)	
	1	M. //			0	C M	E				R 18,		
	30. Name and address of berson			п 23а) (Туре,	Print) 111 PE	NN SI	REET	, BALTI	MOR	E, M	ARYLA	ND, 2	1201
0	31. Date filed (Month_Day_Year	32. A	te <b>s</b> trar's Signa	iture							-		
ie ar	31. Date filed (Month, Day, Year, DEC.	2 2 2004	100.00	K.	Souls								

State Registrar

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			ene g. <b>10</b> 004	42282
			Decedent's Name (First, Middle, Last	it)			D G G I I I	2. Date of Death		3. Time of Death
	Physici /Medic		Vincent i	Anthony	Gittle			Decembe		4 2:35 AM
4	Examin	er	4a. Facility Name (If not institution, give		T1	4b. City, Town, or	Location of Deat	th	4c. County of De	
			Doctor's Community 5. Social Security Number 6. Se		<ul> <li>– Lannam</li> <li>e (In yrs. last birthday)</li> </ul>	Lanham If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Prince (	
	Funeral Director				55 Yrs.	Months Days	Hours Min.	. (Month, Day,	Year) 9. 0	inhplace (State or Foreign Country)
			Usual Residence of Decedent	Λ	33	l	l	sept. 30	, 1949 Mas	ssachusetts
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mar-f st	tor	Maryland Prince (	Georges	Greenbelt					1 ☐ Yes 2 No
	h the	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
	23a o	a D	8415 Canning Terr	race		20770		τ	nited Sta	ates
	deal	ner	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hi	ispanic Origin? (S	Specify Yes or No-	14. Race - An	nerican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Ia markad other than "natural', or Items 23a or 28a-f show appring or other traumatic evant, the Medical Examinar must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	<sup>№</sup> 9–16–69	1 ☐ Yes 2 ☐ No	Specify:	to nican, etc.)	Specify: Wh	
ŏ	2 ho	Completed	15. Decedent's Ed	ucation	16a, Dece	dent's Usual Occup	ation	1	6b. Kind of Busines	
215	within 7 ene. than "n he Med	ple	(Specify only highest gra	de completed) College (1-4or 5	life.	kind of work done of DO NOT use retired	during most of wo f)	orking		
21	d wit	NO.	12		Poli	ce Office	r		Law Enfor	cement
b	be filed tal Hygie d othar evant, II	3e (	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	aiden Surname)	
Maryland	2 should be filed within and Mental Hygiene. Is markad othar than sumatic evant, the Mental than sumatic evant, the Mental than the Mental tha	To Be	William A. Gittle	es			Theresa	a Nurczyk		
lan	2 sho and I la ma		19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Street a	and Number or Ri	ural Route Number,	City or Town, State,	Zip Code)
	of Health of Health if item 27 li		Angela M. Gittles	(wife)	8415	Canning	Terrace	Greenbelt	, MD 2077	70
ore	of He of He fiten r oth		20a. Method of Disposition 1 ☐ Burial 2 【文 Cremation 3 ☐	Demoval from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac	(e) Doc	Date 2	Oc. Location - City of	or Town, State
Ĕ	Pages ment of i ant: If it ury or o		`4 □Donation 5 □ Other (Specify	()	Metropolit	tan Crema	+	004 A	lexandria	. VA
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatura per Funeral Service Licen	see	M00982 42	2. Name and Addres	ss of Facility Ad	lvent Fune e 110 Ann	ral & Cre	mation Ser.
			23a. Part1. Enter the disease, or com	olications that caused						Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.		g, oron ao oanaa	o or roop.natory arrow		Interval Between Onset and Death
			disease or condition resulting in death)	a LUHG		ER				
			f	Due to (or as	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):		- J			
	cuted nd ransit	Examiner	that initiated events	C						
90,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):					
8760,	ate b	dical	•	d						
9	entific fing p	Me.	IF FEMALE:	000 16						
Box	The law requires that the death certifi ste has been signed by the attending rage 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
<u>o</u> .	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5L	Other (specify)				
٩.	hat the d by detac	Ph	Part II. Other significant conditions of	ontributing to death h	ut not resulting in the u	nderwing cause give	an in Part I	23e Did toba	ICCO USA CONTRIBUTA	to the cause of death?
JS,	ires t signe I be d		atti. Ottor signinosii oenationo	orithodaling to dodaling	at not resulting in the a	ricerrying cause give	giriiri cutti.			Probably 4 Unknown
0.0	w requir been si should	etec							2010 00.	Toodsiy T Gommon
Records,	e 2 s	Completed						24a. Was an autopsy	_ prior to	autopsy findings available completion of cause of
F		Cor						perform 1 Ves 2		s 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hamitali		100		ath (Check only one	•	
of	S 0 15	70	1 ☐ Yes 2 █ No	Hospital:		t 3 DOA	er: 4 Nursing H	Home 5 ☐ Residen		ecify)
		on:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	Work	</td <td>28d. Describe how</td> <td>injury occurred</td> <td></td>	28d. Describe how	injury occurred	
sio	Attending r death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division	o te	Certification:	4 Homicide determined	28e. Place of Injury	ury - At home, farm, str c. (Specify)	eet, factory, office		City or Town,	et and Number or F State)	Rural Route Number,
J	pital		29a. Certifier 1 Certifying Ph	vsicien: To the best	of my knowledge, deatl	occurred at the tim	and place	and due to the cau	uso(s) and manner	as stated
	To tha Hospital or Atten within 24 hours after deat To tha Funeral Diractor: completely filled in by the	Medical	(Check only 2 Medicel Examone)	niner: On the basis of and manner sta	f examination and/or in	vestigation, in my or	pinion, death occu	urred at the time, dat	e and place, and du	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	-	/.	29c. License	e number	290	d. Date signed (Mor	nth, Day, Year)
•			Vos 9	in	CBEI	DU	0576	34	0/19/5	+
			30. Name and address of person who	-,	leath (Item 23a) (Type,	Print) Street	1-640	el md	20707	
	Sta	te	31. Date filed (Month, Day, Year)	. Registra	ar's Signature	01,001	ruul	-1	0.0701	
	Sta Registr		DEC 2 1 200	Paker	1 ha	AC)				
		<b>K</b> .		1 - Comment	A POST					

State of Maryland / Department of Health and Mental Hygiene

			AMEND ITEM #5 PER FH G842 4/14/05 Department of Treatment of Neath		No2004 42283						
	Physic	ian	1. December Value (First, Michie, East)	Date of Death     Month	Dey Year 3. Time of Death						
1	/Medi		DORIS LOUISE HILL  4e Facility Name (If not institution, give street and number)  4b, City, Town, or Loc	12	18 2004 2048						
J.	Exami	ner	4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Loc 10320 Bristol Road Ocean Ci		4c. County of Death Worcester						
_	,		5. Social Security Number 0 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.								
	Funeral Director		579-42-7310 1 M 274F 71 Yrs. Months Days Hours Min.	12-26-							
	fand		10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits						
	Mary Mary	ţ	MD Worcester Ocean City		1 □ Yes 2 No						
	or 28	Te e	10e. Street end Number 10f. Zip Code	10g	. Citizen of What Country?						
	th will	aic	10320 Bristol Road 21842		U.S.A.						
Maryland 21215-0020	hours effer death with the Maryland tural', or ferme 23a or 28a-f show al Examiner must be notified at	by Funeral Director	11. Maritel Status  1 □ Never Merried 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 □ No Specify:  13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto Forces)  1 □ Yes 2 □ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indien, Black, White, etc.  Specify: White						
5-0	2 2 2	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin	ng 16	b. Kind of Business/Industry						
121	within ene.	ig I	Elementary/Secondary (0-12) College (1-4or 5+)		Hospitality						
5	Hygiel Hygiel Ther ti	S	12 Food Service  17. Fether's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma							
ano	\$ \$ \$ \$	Be	Benjamin Overby Margar								
Ž	should nd Men marke	5	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural		City or Town, Stete, Zip Code)						
	nd 2		Tammie Nagy Daughter 10320 Bristol Rd.	Ocean (	City, Md. 21842						
Jre,	of Hei		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20	c. Location - City or Town, State						
Ē	Peges nent of int: if Its iry or o		1 □ Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify)  Salisbury Crematory 1	2-22	Salisbury, Md.						
Baltimore,	permit. Depertrimportus any inje		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Ullrich Funeral	Home Be	erlin, Md. 21811						
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.								
	Physician /Medical				Onset and Death						
	₽ #	ne l	the pension								
	ificete be executed g physician end es the buriel-trensit	хаш	Sequentially list conditions, if any leading to immediate		1						
60,	be ey	<u>8</u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):    Cause (Disease or injury that initiated events								
ox 68760,	± 0 Ψ	v/Medical Examiner	resulting in deeth) Last  d								
Box	The lew requires that the death cert ste has been signed by the ettending page 2 should be deteched for use of	Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	acco use contribute to the cause of deeth?						
0	thet the de led by the e	hys	Tattin Still argument Continues to the sound of the sound	1 ☐ Yes	2 No 3 Probably 4 Unknown						
S, D	es the	by F									
Records,	v require been signated			24a. Was an a							
ec.	hes be ge 2 sh	Completed	e:	5500	of death?						
E		S		1 Yes	2 No 1 Yes 2 No						
Vital	certificate	Be	25. Was case referred to medical examiner?  Hospital:   Classical and Content								
o To	Phys this rel di	- To	27. Menn Deeth 28a. Date of Injury 28b. Time of 28c. Injury at 2	ne 5 🗷 Hesideno 28d. Describe how	ce 6 ☐Other (Specify) injury occurred						
O	fing After fune	tlon	1 ✓ Netural 5 ☐ Pending (Month, Ďaý Year) Injury Work? 2 ☐ Accident investigetion M 1 ☐ Yes 2 ☐ No								
Division	or Attending efter deeth. Director: After I in by the fune	Certification:		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	To the Hospital or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fi	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, e 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner steted.	and due to the cau and at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)						
	To the within To the	Me	29b. Signature end title of pertifier  29c. License number	-	Date signed (Month, Day, Year)						
			Oll lees Dyle257		12/22/04						
8	ET.	3	30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)  (8) OU OCEVAN CON (SCVI). (EXCELAR	, all	21811						
	St Regist	ate rar	31. Dete filed (Month, Day, Year) DEC 2 2 2004  32. Registrer's Signeture								

DHMH 16 Rev 6/95

		-	For State Registrar	State of Maryla		artment of H		nd Mental Hy		4 42284
			Decedent's Name (First, Middle,	Last)				2. Date of D	eath	3. Time of Death
	Physicia /Medic		Catharine Loui	se Hopkins				Decemb		04 6:10 AM
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	r Location of	Death	4c. County of	Death
			14120 Cedarfie			Hager	stown	d Health and the	Wash	ington County
	Funeral	ı	, , , , , , , , , , , , , , , , , , , ,	1 1 M 407 E	rs. last birthday) <b>50</b>	Months Days	If Under 2 Hours	Min. (Month, D	26 1954 I	. Birthplace (State or Foreign Country) Marsyland
	Director		214 46 5299 Usual Residence of Decedent		30			August	20 1.754 1	atyland
	rylanc how		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	Be-f s	cto	Pennsylvania F	ranklin	Wayne					1 ☐ Yes 2 🛣 No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
	death with the Maryland ums 23e or 28e-f show if must be notified at	eral	4436 Ironbridg	e Road  12. Was Decedent Ever in	U.S. 13	1723		in? (Specify Yes or N		S.A. American Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-f show other traumatic event, its Medical Exam and the notified at	by Funeral	Never Married 2 Marrie  3 Widowed 4 Divorced	Armed Forces?		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	in? (Specify Yes or N Puerto Rican, etc.)	Black,	White, etc. White
2-0	72 ho	Completed	15. Decedent's (Specify only highest		16a. Dece	edent's Usual Occup	ation	of working	16b. Kind of Busin	ness/Industry
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	or woming		
2	e filed wall Hygier other the		12 17. Father's Name (First, Middle, Li	acti	Pr	ess Opera		's Name (First, Middle		er Company
ano	ntal Hed of	Be								
Z	2 should be to and Mental I is marked or aumatic eve	မှ	John H. Hopkin  19a. Informant's Name/Relationshi		19b. Mail	ing Address (Street		marie Flei or Aural Aoute Numl		ate, Zip Code)
<b>∑</b>	nd 2 s lith ar 27 is rtrau		Susan E. Rude	(Friend)	89	65 Willia	mspor	t Pike Fal	ling Water	rs, WV 25419
ē,	s 1 and 2 of Health a Item 27 Is other trau		20a. Method of Disposition		o. Place of Disp	osition (Name of ematory or other place		Date	20c. Location - Cit	
E	Pages nent of ant: If It ury or o		1 ☐ Burial 2 🛣 Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe	∃ □Removal from State ecify) S		rg Cremat		2-24-2004	Smithsbu	rg Maryland
Baltimore,	permit. Pages Department of friportant: If It ary injury or one		21. Signature of Fun ral Service Li	O-Paulou	Tr. 1					uneral Home aryland 21742
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused the de	eath. Do not en					Approximate Interval Between
豐	Physician	87 N	Immediate Cause (Final disease or condition	Rr	vain	moto	101	0.040		28 months
	/Medical		resulting in death)	Due to (or s a cons	sequence of):	1 0				20 110011112
	Examiner		Sequentially list conditions,	b	eas	tu	unc	er		11 years
	sit s	iner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Clie to (or as a cons	saquanga crjs					0
	and and II-tran	Examin	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):					=
8760,	icate be executed physician and s the burial-transit	dlcal E								
687	ificate g phy: as the	edlo								
Вох	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		□Ectopic pregnancy	,		23d. Date of	
		sicla	in the past 12 month <i>s</i> ? 1 □ Yes 2 □ Vo	4 Pregnant at time of		Other (specify)	y 		Month	Day Year
P.0	at the de by the a stached	hys	9 Unknown							
	The law requires that ite has been signed b age 2 should be deta	by	Part II. Other significant condition	s contributing to death but not	resulting in the	underlying cause giv	ren in Part I.			ute to the cause of death?  ☐ Probably 4 ☐Unknown
Vital Records,	The law requirate has been page 2 shoul	Completed		-				24a. Wa auto peri 1 \( \text{Yes}	opsy prio	re autopsy findings available or to completion of cause of the?  Yes 2 \sum No
/ita	Physiclen: this certific ral director,	Be (	25. Was case referred to medical examiner?			15.		of Death (Check only	one)	iend & Holse
of	Physic this c	은	1 ☐ Yes 2X No		ER/Outpatie	the state of the state of	4 LI Nur	sing Home 5 Res		
	fter	lon	27 Manner of Death Natural 5 Pending		28b. Time ( Injury	Wor	ryat rk? Yes 2 □ N		how injury occurred	
Division	Attending r death. ector: After y the fune	icat	2 Accident investigated as Suicide 6 Could no	ot be 390 Place of laive. A	thome farm, s		103 2 1		(Street and Number	or Rural Route Number,
Div	P = E	Certification:	4 ☐ Homicide determin	building, etc. (Spe	ecify)	and an analysis of the same			own, State)	
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical C		Physician: To the best of my xaminer: On the basis of exam and manner stated.						
	Fo the Vithin Fo the Compl	Me	29b. Signature and title of certifier		۸۸	29c. Licens	se number		29d. Date signed (/	Month, Day, Year)
)		l	Hhid H	Lung	١٧١	D	HALL	73	12/27	104
	15		30. Name and address of person w	no completed cause of death (	Item 23a) (Type	, Print)				21141
ئے	1		HindHa	undan. 1	CIN	1130 (	OPAI	CT.	Hage	istown, MI
	Sta Regist		31. Date filed (Month) (Pap Year)	2004 32. Registrar's Si	gnature /	hoe sto			, ()	

DHMH 17 Rev 1/2001

ORIGINAL

	1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of I	lealth and Death		iene2004	4228	
Physician /Medical Examiner	4a. Facility Name (If not institution,	1S give street and numbe	or)		or Location of Dea	2. Date of Deat Month Decembe	er 18, 2004	ith	
Funeral	Holy Cross Hosp 5. Social Security Number 248-70-4742		Age (In yrs. last birthday) 61 Yrs.	Silver  If Under 1 Year  Months Days			Montgon	thplace (State or Foreigountry) LON, GA	
Director would be be be be be be be be be be be be be	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation Ston, D.C		INOV. 9,	1943 Eat	10d. Inside City Limits	
utter death with the Mai in terms 23a or 28e-1 si in act must be notified Funeral Director	D.C. 10e. Street and Number 4105 Wisconsin	Avenue NW		10f. Zip Code 2001		1	0g. Citizen of What Co		
18 18 S	3 ☐ Widowed 4 🏋 Divorced	12. Was Deceder Armed Force	nt Ever in U.S. 13. s? ] No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi Specify: W		
e filed within 72 hou all Hygiene. I other then "nature vent, the Medical E	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	prking	16b. Kind of Business Medicine	/Industry	
es 1 and 2 should be filed of Health and Mental Hygic of Health and Mental Hygic if them 27 is marked other ir other traumatic event, To Be Co	17. Father's Name (First, Middle, L		19b. Maili	ng Address (Street	Minnie	me (First, Middle, Me Lee Muri	_	Zin Code)	
ges 1 and 2 s t of Health ar if item 27 is or other trau		riend	20b. Place of Dispondent Commetery, cre	Wisconsi esition (Name of matory or other pla	n Ave. N	W Washing	gton, DC 20 20c. Location - City or	0016 Town, State	
permit. Pages 1 Department of F Important: If ite eny injury or ot once.	→ Donation 5 Other (Sp. 21 Signature of Funeral Servisor)			on Center Murphy 510 Wilso	1	2/24/04 Home Arlington	Chantilly n, VA 222		
death certificate be executed e attending physician and contract transit and for use as the burial-transit contract.  Iclan/Medical Examiner		a. Lung Due to (or a	Cancer Met as a consequence of):		ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Criset and Death 1 Year	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1				,		23d. Date of del Month	livery Day Year	
es if	Hypertension						icco use contribute to the cause of death? 2 □ No 3 ∯Probably 4 □Unknowi		
The page							tas an utopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
Attending Physician: T ar death. ector: After this certificate by the funeral director, perification: To Be Co	examiner? 1 Yes 2 Xio		jury 28b. Time o	f 28c. Injur Wor	er: 4 🗆 Nursing l	ath (Check only one dome 5 Reside 28d. Describe ho	nce 6 □Other (Spe	city)	
To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dI Medical Certification: To Medical Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num. City or Town, State)								
To the Hospi within 24 hou To the Funer completely fill	29b. Signature and title of certifier	xaminer: On the basis and manner	of examination and/or in stated.	29c. Licens	e number	urred at the time, da	ate and place, and due	h, Day, Year)	
State Registrar		APALL	strar's Signature	995EC	OND A	IENUE,	SILVER	SPRING- 20910	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Lillian Holland Dec 18 2004 8:30 pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Charles County Nursing Home LaPlata Charles Hours Min. 8. Date of Birth (Month, Day, Year) Dec 18 1921 9. Birthplace (State or Foreign Country) Washington, DC If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 83 1 ☐ M 2 🖾 F Yrs 228-18-0879 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health end Mental Hygiene. I flem 27 is marked other than "natural", or items 28a or 28a-f show or other trsumetic event, the Medical Examiner must be notified at 11 Yes 2 □ No Funeral Director MD LaP1ata Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 USA 10200 LaPlata Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: ð White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) home-maker own-home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lily Mae Shephard William Francis Wiley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10200 LaPlata Road, LaPlata, Md. 20646 William H Holland - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Peges
Depertment of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 6 4 ☐ Donation 5 ☐ Other (Specify) Mount Comfort Cemetery 12/21/04 Alexandria, Va. 22. Name and Address of Facility Everly Wheatley Funeral Home 21. Signature of Funeral Service Licenses roa 1500 W. Braddock Rd. Alexandria, VA. 22302 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) LAC /Medical **Examiner** Physician/Medical Examiner within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use es the buriel-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be activated to the cause of the cause Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 9nknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Tes 2000 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1/7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier al 20602 s of person who completed cause of death (Item-23a) (Type, Print) BUL Mellon 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		•	For State Registrar	State of M	laryland /	Depa Ce	artment of H rtificate of	lealth a	and M		Reg. No.	004	42	287
	Physici	an	1. Decedent's Name (First, Midd Charles	tie, Last) W •	Hoffm	an			Ì	2. Date of De Month Decembe	Day	Year 2004	3. Time of 3:25	f Death p M
}	/Medic Examin		4a. Facility Name (If not institution			idii_	4b. City, Town, o	or Location of		Decemb		nty of Death		
	Examin	E!	Genesis Elder	-		•	Silver				Mor	ntgome	ry	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last b	•	If Under 1 Year Months Days		_	8. Date of Bir (Month, Da	th V Year	9. Birth	place (State o	or Foreign
	Director		578-12-6081	12€ M 2□ F	83	Yrs.	World S Days	Hours		May 22			hingtor	n, DC
	pur *	1	Usual Residence of Decedent  10a. State 10b. Count	v	10c. City, To	wn or Lo	ocation						10d. Inside C	ity Limits
	Aaryla f eho	5		tgomery	Silve	r Si	oring							2x №
	the N	Directo	10e, Street and Number	regomery			10f. Zip Code				10g. Citizen	of What Cou	untry?	
	3a or	Ö	3005 South Le	isure World	Blvd, #	504	209	06			USA			
	within 72 hours after death with the Maryland ene. than "naturel", or Itams 23a or 28a-f ehow the Medical Exant art must be notified at	Funerai	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S.	13.	Was Decedent of H	Hispanic Ori	igin? (Spe	cify Yes or No	)- 14. F	Race - Amer		
9	after or Ite	Fu	1 ☐ Never Married 2 Ma	rried 1 X Yes 2 [	] No		1 ☐ Yes 2 🛣 No			ncan, occ.)	1	Black, White Acify: Whi		
21215-0036	ural',	d by	3 Widowed 4 Divorce	Year or Dates										
7	"nat	Completed		nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos	st of workir	ng	16b. Kind o	f Business/Ir	ndustry	
2	within	d d	Elementary/Secondary (0-12)	College (1-4o	r 5+)		ctronic E		er		United	States	Governme	ent.
<u>5</u>	filed Hygi other ent, I	Be C	17. Father's Name (First, Middle	, Last)						(First, Middle				
lan	lid ba fental rkad ric av	To B	Charles Hoffm	an				Agn	nes B	eetz				
Maryland	shous and has man		19a. Informant's Name/Relation	ship (Type, Print)	19	9b. Maili	ng Address (Street	and Number	er or Rura	Route Numb	er, City or To	wn, State, Zi	ip Code)	
Σ	and 2 salth n 27 I		Marian Ricker	Hoffman/Wife			outh Leisur	e World	d Blvd	1, #504,	Silver	Spring,	MD 2090	06
ore	of Ha		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 □Removal from Stat	20b. Place cemel	of Dispo	osition (Name of matory or other pla Heaven	сө) [		ber 21	20c. Location	on - City or T	own, State	
Ē	tant:		' 4 □ Donation 5 □ Other (	Specify)	_	Ceme	tery		200				nj, Ma	rylan
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-1 show any highry or other traumatic avent, its Medical Exam and its chilled all once.		21. Signatur 1 Bineral Service	ami	9	F 50	rancis dir.	sity	ins Blvd	Funera , W, S	l Home ilver S	Inc Spring	,MD 20	901
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.									Approximat Interval Bet Onset and	ween		
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	/Medical Examiner		resulting in dealin)	Due to (or a	s a consequenc	e of):								
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	utad 1 Insit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury	Carcing	noma of	Pro	state							
Ć.	exectin and ital-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a consequenc	e of):		•						
8760,	death certificate be executad e attending physician and id for use as the burral-transit	Physician/Medical		d										
89	artifica ing ph as ti	Med	IF FEMALE:										***	
Вох	eath certific attending p I for use as I	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pregnanc	у				Date of delive	,	Year
<u>o</u>	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∟Pregnant 9□Unknown	at time of death	5 L	Other (specify) _		-				,	
<b>_</b>	The law requires that the tee has been signed by the sage 2 should be detached.		Part II. Other significant condi-	tions contributing to death	but not resulting	in the u	inderlying cause giv	ven in Part I	l,	23e. Did t	obacco use c	ontribute to	the cause of d	leath?
Vital Records,	uires I sign Id be	d by								10	Yes 2 □ No	3 ☐ Pro	bably 4 🔀	Jnknown
00	w requir been si should	Completed								24a. Was	an 24	b. Were aut	opsy findings	available
Re	The lav	duo									osy ormed?	prior to co death?	ompletion of c	
ta		O	25. Was case referred to medic	al				26. Place	e of Death	(Check only	3(3)No	1 🗆 Yes	2 INO	
<u> </u>	nysician: ns certifica director, I	To B	examiner? 1 ∐ Yes 2 🔀 No	Hospital: 1 ☐ Inpa	tient 2 ER/0	- Outpatier	nt 3 DOA Ott	205		ne 5□Resi		Other (Speci	ify)	
n of	Attending Physician: r death. sctor: After this certific. by the funeral director,		27. Manner of Death 1 X Natural 5 ☐ Pend	28a. Date of In (Month, D		. Time o	f 28c. Inju Wo	ry at rk?	2	8d. Describe	how injury oc	curred		
Sio	Attendia death. ctor: Ai y the fu	atic	2 ☐ Accident inves	tigation			M 1	Yes 2	No					
Division	l or Atten after deat Director: I in by the	ertification;	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	mined 286. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, st	reet, factory, office		2	l8f. Location ( City or To	Street and Nu wn, State)	mber or Rur	ral Route Num	ber,
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai		ring Physician: To the best at Examiner: On the basis and manner	of examination a									·)
	To the within 2 To the complet	Me	29b. Signature and title of certif	ier			29c. Licens	se number			29d. Date sig	ned (Month,	Day, Year)	
)	-11		1 Spron	ne hu	temp		D56	6691		,	Decembe	or 16	2004	
	1211		30. Name and address of perso	n who completed cause of	death (Item 2)	a) (Type,	Print)						_004	
			Ghousia Sul			lerit	tage Park	Circ	le, S	Silver	Spring	, MD	20906	
	Sta	te ar	31. Date filed (Month, Day, Yea DEC 21	2004 32. Regis	strar's Signature	9	Sparks							

			1- For State of Maryla Registrar		artment of Healt rtificate of Dea		ntal Hygier	2001	42288	
	Physici /Medi	cal .	Decedent's Name (First, Middle, Last)  Joseph Wellington Hess  4a. Facility Name (If not institution, give street and number)		Ab City Town and again	D	ecember	Day Year 20, 2004	3. Time of Death 7:00 A <sup>M</sup>	
	Examir Funeral Director	ner	8308 Tomlinson Avenue  5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yr	rs. last birthday) 7 7 Yrs.	Bethesda  If Under 1 Year If Under 1 Year Hou	der 24 Hrs. 8.		4c. County of Death Ontgomery 9. Birth Cot 7 Penn		
	he Maryland 28e-f show ciffied at	ector	MD Montgomery Be	City, Town or Lo					10d. Inside City Limits 1 X Yes 2 ☐ No	
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28e-f show ant, the Modical Examiner must be notified at	by Funeral Director	10e. Street and Number  8308 Tomlinson Avenue  11. Marital Status  1 □ Never Married 2 Married  12. Was Decedent Ever in Armed Forces?  1 □ Never Married 2 Married  11. Yes 2 □ No		10f. Zip Code 20817  Was Decedent of Hispanic If Yes, specify Cuban, Mex			U.S.A.  14. Race - Amer Black, White  Specify: Whi	ican Indian, , etc.	
21215-0036	ed within 72 hours giene. er than "natural".	Completed b	3 Widowed 4 Divorced Year or Dates: WWI  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  5+	16a Decer	dent's Usual Occupation kind of work done during ripo NOT use retired)  1 Engineer	most of working	Fe	Kind of Business/lederal Hig	ndustry ghway	
Maryland 21	iould be filed I Mental Hygid narked other natic event, the	To Be (	17. Father's Name (First, Middle, Last)  Der1 Hess	10000000	A1	ice Con				
re, mar	is 1 and 2 sh of Health and item 27 is m		19a. Informant's Name/Relationship (Type, Print)  Eva Hess, Spouse  20a. Method of Disposition	8308	ng Address (Street and Nui Tomlinson Av sition (Name of natory or other place)		ethesda,		20817	
Baltimore,	permit. Pages 1 and 2 should be fo Oopartment of Health and Mental In Important: If item 27 is marked of any injury or patter traumatic even once.		I Dunai 2 Micromation 2 Desilovation 3tate	Linco	1n Crematory Name and Address of Fa	acility Sim	ple Trib	ute		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. Let only one cause on each lin. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a const	PNEU	er the mode of dying, such			ie, maryi	Approximate Interval Between Onset and Death	
,	eate be executed by sician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Described or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of the							
Box 68/60	ih certificate be e ending physicial r use as the buri	edical	d		Dectopic pregnancy			23d. Date of deliv	,	
	at the death by the atten stached for u	Physician/M	1  Yes 2 No 4 Pregnant at time of 9 Unknown	death 5	Other (specify)			Month Day Year		
ecords, I	w requires that the death certific been signed by the attending f should be detached for use as	by	Part II. Other significant conditions contributing to death but not re	ner significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  1   Yes 2   10 3						
итаі жес	The lar ate has page 2	e Completed					24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of	
0	Phy this	To B	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  1 Inpatient 2 (Month, Day Year)	ER/Outpatien 28b. Time of Injury						
DIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At building, etc. (Spec	cify)		W.	City or Town, Sta			
	the Hosp nin 24 hoi the Fune npletely fi	<b>l</b> edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my known one)  Certifying Physician: To the best of my known one one of the best of my known one of the best	nowledge, death nation and/or inv	estigation, in my opinion, o	death occurred a	t the time, date a	nd place, and due to	o the cause(s)	
	T North	W	29b. Signature and title of certifier		DO05			ate signed (Month,		
	10		30. Name and address of person who completed cause of death (lte Dr. Truong Bao, 13219 Executiv	e Park '		mantown	, Maryla	nd 20874		
	Sta Registr	_	31. Date filed (Month, Day, Year)  DEC 21 2004  32. Registrar's Sign	nature	Spark					

		1	For State Registrar	State of M	aryland /	Departmen Certificate			d Mental Hy	giene2 0	04 42289
			Decedent's Name (First, Middle	, Last)					2. Date of De	ath	3. Time of Death
	Physicia	ın			+ AWK	INS, 5R			D4CEM	B42192	Vear 0220M
	/Medic Examin		4a. Facility Name (If not institution			NTER 4b. City,		Location of D		4c. County	
1	Examin	2.0	BROOFE GROVE REHA	BILLTATUN ANY	NURSIN	GA SAN	Nac	SPRI	NG	Mon	TGOMERY
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last t	oirthday) If Under		If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th V Year)	Birthplace (State or Foreign Country)
п	Director		215-20-3310	<b>½</b> □M 2□F	80	Yrs. Months	Days	Hours	May 18	1924	Maryland
	<b>D</b>		Usual Residence of Decedent		140. Oil T.						10d. Inside City Limits
	irylar show	_	10a. State 10b. County		10c. City, 10	wn or Location					1 ☐ Yes 2 ☐ No
	Be-f s	5		Montgomery		Silver Sp					
	ith th	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of V	√hat Country?
	236 181	<u>a</u>	15301 Pine Or				0906			US	
	r des	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Deced	dent of His cify Cubar	spanic Origin n, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	)- 14. Hac Blac	e - American Indian, k, White, etc.
36	or II	Y	1 Never Married 2 Marr 3 XWidowed 4 Divorced	If Yes, Give	<sup>№</sup> 1943-	45 1□ Yes	2 <b>∛</b> □ No	Specify:		Specify	White
21215-0036	72 hours after death with the Maryland natural; or Items 23e or 28e-f show disal Examinat nust be multified a	Completed by	15. Deceden	Year or Dates:	16	Se. Decedent's Usua	al Occupa	tion		16h Kind of Bu	usiness/Industry
-5	"nat	ete	(Specify only highes	st grade completed)		(Give kind of wo	rk done di	uring most of	f working		,
12	withii ene. than	m	Elementary/Secondary (0-12)	College (1-4or	5+)	Fire Ch	ief			Federal	Government
d 2	filed Hygi ther ont,	မ ပ	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	, Maiden Suman	16)
an	d be antai sed o	<b>B</b>	Maynard Levi	Hawkins				01i	ve Estell	e Bailey	7
Maryland	d Me mark	၉	19a. Informant's Name/Relations		= 1	9b. Mailing Address	(Street a		or Rural Route Numb		
<b>∑</b>	d 2 s th ar trau		James W. Hawki			12004 Suf	folk	Terra	ce, Gaith	ersburg.	MD 20878
ō,	Heal Heal tem		20a. Method of Disposition		20b. Place	of Disposition (Nar	ne of		Date		City or Town, State
<u></u>	Se E SO		1 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S			tery, crematory or o wn Memorial		DC.	cember 23 2004	Pockwill	e, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural; or Items 23e or 28e-f show emportant: If item 27 is marked other than "natural; or Items 23e or 28e-f show employer you her traumatic event, the Medical Examiner must be rigitlized at ance.	1	21. Signature of Funeral Service		ranta				ns Funera		
Ba	permit Depar Import eny ir		Kohert	Exam	70.	Franci	s J.	Colli sitv P	ns Funera Nyd. W. S	l Home I	inc. oring, MD 20901
			23a. Part1. Enter the disease, or	complications that cause	d the deeth B						Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each I	ine.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	a consequence	PNZUM	OP			· · · · · · · · · · · · · · · · · · ·	2 WEEKS
	Examiner			Due to (or as	a consequent	, d 01).					
		e e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequent	a uf).					
	tinsit	듄	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> . –							
_,	be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as	a consequent	ce of):					
760,	eath certificate be e) attending physician for use as the buria	call		d							
687	fficate g phy as the										
Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							te of delivery
ă	d for	cla	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant a						Mo	onth Day Year
P.O.	the carbe	hys	9 Unknown	9□ Unknown							- United the state of the state
σ.	uires that the death signed by the atte d be detached for	Y P	Part II. Other significant conditi						23e. Did	tobacco use cont	ribute to the cause of death?
rds	quire n sig ald bu	Completed by	SENILE DEN	KENTIA (PRI	BABL	4 VASCL	LAP	L);	_   1□	Yes 2□No	3 Probably 4 XUnknown
OS	w requir	lete	ATRIAL FIB	RILLATION	: HY	PERTEN	Sia	ے '	24a. Wa	s an 24b.	Were autopsy findings available
Re	aician: The law certificate has t irector, page 2 s	m.	1111-111-11		1				auto per 1 ☐ Yes	órmed?	prior to completion of cause of death? 1 ☑ Yes 2 ☑ No
ā	10	Ö	25. Was case referred to medica	1				26. Place o	f Death (Check only		
Ξ	Phyaician: r this certific ral director,	OB	examiner? 1 ☐ Yes 2 🕱 No	Hospitals	ient 2□ER/	Outpatient 3 D	OA Othe		ing Home 5 🗆 Res		er (Specify)
Division of Vital Records,	ding Phyaician: n. After this certific funeral director,	$\vdash$	27. Manner of Death	28a. Date of Inj	F-1000		28c. Injury Work			how injury occur	
on	ding F th. After funer	tlo	1 Natural 5 ☐ Pendii 2 ☐ Accident investi	9	ay rear)	Injury M		Yes 2⊡No			
/isi	Attending r death.	Certification;	3 Suicide 6 Could	ained 289. Place of it	njury - At home	, farm, street, factor	y, office			(Street and Numb	per or Rural Route Number,
Ö	al or afte Dire	ert	4  Homicide	Ballaing, E	itc. (Specify)				0.19 0. 10	,, oldto)	
	Hospital or 14 hours afte Funeral Dir tely filled in	<u>a</u>	29a. Certifier La Certifyi	ng Physicien: To the bes	t of my knowle	dge, death occurred	at the tim	ne, date and	place, and due to the	cause(s) and ma	anner as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medicel one)	Exeminer: On the basis and manner s	or examination tated.	and/or investigation	ı, ın my op	pinion, death	occurred at the time	, uate and place,	and doe to me cause(s)
	To the within To the comp	M	29b. Signature and title of certific	ər		29	c. License	number	, 7		d (Month, Dey, Year)
			Spm AT	TENO NG	PAYSI	LIAN	V4	2041	0	DECEM	Ser 19, 2004
	15+1		30. Name and address of person	who completed cause of	death (Item 23	la) (Type, Print)		Λ			36R 19, 2004 20860 MARYLAND
	, -		GRACE BROOKEL	NEFMAN, MI	D- 18100	SLADES	CHOO	L LOAD	SAMONS	PRING	MARYLAND
	St	ate	31. Date filed (Month, Day, Year	2004 32. Pegis	trar's Signature	& Sp	a. V.	1	-		
	Regist		DEC 21	ZUU4	,	10 10ps	ours				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Angelene Gladys Hoffman December 16, 2004 1:45 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Dorchester Cambridge 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗓 F 219-01-6754 87 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinal intel by rigitified at 10d. Inside City Limits 1 Yes 2 □ No Maryland Dorchester Cambridge Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Glenburn Avenue 21613 USA death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked other then "natural, or Iter Black, White, etc. Baltimore, Maryland 21215-0036 ∕ 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Clothing Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Medford Stoker Maggie Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr eny injury or other traum once. Norman W. Hoffman/Son 6111 Eldorado-Federalsburg Road, Rhodesdale, MD21659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 12/18/2004 | East New Market, MD 21. Signature of Funeral Service I 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD ense 21631 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dUMvaed **Physician** disease or condition resulting in death) 20 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably Completed 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate has autopsy performed 1 Yes To the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 0 1 Tes 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending after death. investigation М 1 Tes 2 No 2 Accident nin 24 hours after death the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide 12 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 2 29b. Signature and title of certiful 29d. Date signed (Month, Day, Year) W MO address of person who completed cause of death (Item 23a) (Type, Print) 302 CULLING en MO 31. Date filed (Month, 32. Regierar's Signature State Registrar

			1- State of Maryland /	Depa		Health and		_	1
	Physici	ian	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	_	3. Time of Death
	/Medi	cal	Robert Lynn Ingram  4a. Facility Name (If not institution, give street and number)		4h City Town	arl casting of D	Dec.	22, 200	4 3:20 P M
1	Examir	ner	Avalon Manor Nursing Home		Hagers	or Location of Do	eatn	4c. County of D	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last i	birthday)	If Under 1 Yea	r If Under 24 h	Irs. 8. Date of Birth		Birthplace (State or Foreign Country)
	Director		218-30-7849 1 <sup>1</sup> M 2□ F 71 Usual Residence of Decedent	Yrs.	Months Days	s Hours M	8. Date of Birth (Month, Day, Aug. 23,	1933 N	Maryland
	Marylar Iso a	tor	10a. State 10b. County 10c. City, To Maryland Frederick Keyma		cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the	lrec	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	t Country?
	ath wi	ral	12111 Legore Bridge Rd.		217	57		USA	
920	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or Items 23e or 28e-f show event, the Mudical Examilian must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☒ Yes 2 □ No 1951 −  If Yes, Give Year or Dates: 1954		Was Decedent of f Yes, specify Cui 1 ☐ Yes 2 💢 No		(Specify Yes or No- erto Rican, etc.)	Black, V	American Indian, Vhite, etc. White
15-0	"natur	leted	15. Decedent's Education (Specify only highest grade completed)	a. Deced	ient's Usual Occu	upation e during most of ed)	vorking	6b. Kind of Busine	ess/Industry
21215-0036		Completed	Elementary/Secondary (0-12) College (1-4or 5+)		er and (			Shipbuil	ding
Maryland	should be filed nd Mental Hygi marked other imetic event, II	Be	17. Father's Name (First, Middle, Last)  Taft Theodore Ingram			24 - 1	<sub>lame (First, Middle, N</sub> eletta Gar		
Ë	s 1 and 2 should f Health and Men item 27 is marke other treumetic	2		9b. Mailin	a Address (Stree		Rural Route Number,		te Zin Code)
	and 2 sealth ar					Bridge		r,MD 217	
Baltimore,					sition (Name of natory or other pla			Oc. Location - City	
Ē	Pa nen ury		`4 □Donation 5 □Other (Specify) ☐ Smith	sbur	g Crema	tory 12-	23-2004 S	mithsbur	g.Maryland
Bal	permit. Departr Importe any inji		21. Signature of Feneral Septe Compe				sborne Fun		e,P.A. rt,MD 21795
			23a. Part1. Phter the disease, or complications that caused the death. Do shoot, or heart failure. List only one cause on each line.						Approximate Interval Between
4	Physician :		Immediate Cause (Final disease or condition a. CHRO NIC resulting in death)	OB.	STRUC	TIVE !	PULMOWAR	LY DISEA	Onset and Death
	/Medical Examiner		Due to (or as a consequence	e of):				8.	
	sit sd	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		No.				13/
	be executed siclan and burial-transit	Examiner	Cause Disease or injury that initiated events c	e of):					
68760,	ate be hysicia the bun	cal	d						
P.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnand Other (specify)	cy		23d. Date of Month	delivery Day Year
rds, P.	iires tha signed d be de	þ	Part II. Other significant conditions contributing to death but not resulting	in the un	iderlying cause gi	ven in Part I.			e to the cause of death? Probably 4 □Unknown
Il Records,	: The law requested has been page 2 should	Completed		·			24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of 1? Yes 2 \( \sum \) No
Vital	Physicien: this certificatal director, I	Be	25. Was case referred to medical examiner?  Hospital:	-	Ot	L	eath Check on one		
o	Physer this eral di	n: To	1 Impatient 2 EH/C	Time of	28c. Inju	47 Nursing	Home 5 Residen		(pecify)
ion	Attending or death. ector: After by the fune	atlo	2 Accident investigation	Injury		ork? ]Yes 2 ☐No			
Division	l or Attenc after death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
	spite hours inerel y filled	Medical Ce	29a. Certifier (Check only one)  (Check only one)  (Check only one)	ge, death ind/or inv	occurred at the ti estigation, in my	ime, date and pla opinion, death oc	ce, and due to the car curred at the time, dat	ise(s) and manner e and place, and c	as stated. due to the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier		29c. Licen	se number	290	d. Date signed (Mo	onth. Day, Year)
			Onti		D	5232	3	12/23/	04
. A <sup>1</sup>	4-0+1.		30. Name and address of person who completed cause of death (item 23a		,				
	Sta	ta.	Khalid Waseem M.D. 1126 Opal Co	ourt	Hager	stown,MD	21740		
	Registr	16	DEC 25 2004 Massim S.	fil.	e state				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Johnson 10:18 A Dec 2004 /Medical 4a. Fecility Name (If not institution, give street and number) Sounty of Death 4b City Town, or Location of Death Examiner Washington If Under 1 Year If Under 24 Mrs. 8.1 rince Georges 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex **Funeral** Months 1 □ M 2 □ 219-68-5512 Yrs. Director Washington Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Count 10d. Inside City Limits 28e-1 show other traumatic event, the Medical Examiner must be rigitiled at 1 des 2 No Director rince Georges 10e. Street and Number 10g. Citizen of What Country? ō Court or items 23e Brandy hall Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hyglene. Is marked other then "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Fashion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helena Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) perniit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is n any injury or other traun once. Ft Washington Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State esurrection Cem. 1 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Ralph Williams Fune.
18/3 Potomer Ave. SE Funeral Service Licenses Washington DC ZOWS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit 0 the attending physician and hed for use as the burial-tran Due to (or onsequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 2 1 🗌 Yes 2 🗷 No 3□ DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Amir M. Alikhani

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

			1 - For State Registrar		aryland / i		tificate c			eg. No.	004	42293
	Physici		Decedent's Name (First, Middle, Las     ANNA     M	AE	KELBAU	GH			2. Date of Dea Month DECEMBE	- Day	Year 2004	3. Time of Death 6:57A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town	n, or Location of	Death		County of Death	
	•			AL HOSPIT			FREDER			FF	REDERICK	
	Funeral Director			x	e (In yrs. last bii 92	Yrs.	If Under 1 Ye Months Da		Min. 8. Date of Birth NOV . 1 ,	<sup>'</sup> 191	9. Birth	place (State or Foreign ARYLAND
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	m or Loc	ation					10d. Inside City Limits
	Ba-fal	Director	MARYLAND WASHI	NGTON				KNOXVII				1 ☐ Yes 2√ No
	death with the Maryland ims 23a or 28a-f ahow ims Le nailled at	al Dire	704 WEVERTON ROA	D			10f. Zip Cod	21758	1	0g. Citia	zen of What Cou U.S	
350	be iiled within 72 hours after death with the Marylar at all tygiene. And Hygiene. And other than "natural; or Itams 23a or 28a-1 ahow avent, It a Modical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 Yes 2 7 If Yes, Give Year or Dates:		1	/as Decedent of Yes, specify O		n? (Specify Yes or No- Puerto Rican, etc.)	- 1	14. Race - Ameri Black, White Specify:	
212-0030	72 hor	eted	15. Decedent's Edi (Specify only highest grad		16a	. Decede	ent's Usual Oc aind of work do	cupation ne during most o tired)	of working	16b. Kir	nd of Business/Ir	
N	d within giene. ar than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. D		EMAKER			OWN	HOME
Maryland	ild ba tite lental Hy kad othu ic avant	To Be (	17. Father's Name (First, Middle, Last) CHARLES ASHBY CO	ULTER					s Name (First, Middle, A MAE MAIN	Maiden :	Sumame)	
Mary	id 2 should th and Mer 17 Is marks traumatic	-	19a. Informant's Name/Relationship (7. FRANKLIN L. KELB						or Rural Route Number			
ore,	of Healt of Healt if itam 2 or othar		20a. Method of Disposition 1 🕅 Burial 2 🗀 Cremation 3 🗀		20b. Place o	f Dispos	ition (Name of atory or other)	place)	Date		cation - City or T	
Ě	parmit. Pages Department of Important: If it any injury or o	. 0	'4 □Donation 5 □Other (Specify,		OLD BR	_		CEM. 12 dress of Facility	2/30/2004	BROW	NSVILLE	, MARYLAND
מ	parm Depa Impo any i		The state of the s			841	BAST FU	UNERAL H	BOONS:	BORO	NATIONA , MARYL	L PIKE AND 21713
	Fliysician :		23a. Part1. Enter the disease, or comb shock, of heart failure. List only of immediate Cause (Final disease or condition	lications that caused ne cause on each lir					ardiac or respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a Due to (or as	a con uence	of):	Cto	LIZUN	10100000			10 years
	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to [or as	a cons » uence	of):		D( 07 13				( 4,5)
eu,	tificate be exacuted ig physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):				-		
09/90	ificate g phy as the	fedical		d				_				
O. Box	The law requires that the death cart tie has been signed by the attendingage 2 should be detachad for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregna Other (specify,			2	3d. Date of deliv Month	ery Day Year
л, Г	ires that t signed by d be detar	by	Part II. Other significant conditions of	Tailur	ut not resulting i	n the un	derlying cause	given in Part I.	23e. Did tol			he cause of death?
necords,	w require been si should b	letec	TICAL COM	1 000					24a. Was a			opsy findings available
		Completed							autops perform	v	prior to co death? 1	mpletion of cause of
VII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:	-1 2 TER/O		4E DO4	Other	f Death (Check only on			
5	g Phys er this eral di	-	1 Nes 2 No 27. Manner of Death	28a. Date of Injur	y 28b.	Time of	28c. ir	njury at	ing Home 5 Reside			ÿ)
DIVISION	Itanding F death. tor: After the funer	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day		njury	M 1	Vork? ☐ Yes 2 ☐ No				
2	spital or Attancours after death ours after death naral Director: filled in by the i	Certification;	4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, fa c. (Specify)	irm, stre	et, factory, offic	Ce Ce	28f. Location (St City or Town			al Route Number,
	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best oner: On the basis of and manner sta	examination an	e, death	occurred at the estigation, in m	time, date and y opinion, death	place, and due to the ca occurred at the time, d	ause(s) a ate and	and manner as s place, and due to	tated. o the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	117	<			ense number	2 7	9d. Date	signed (Month,	Day, Year)
	6		30. Name and address of person who c	e Mil		(Type 5	-	2203	, (	12	126/20	04
ار	۲-5		L Kinland	MD			TINO A	VE	Branswice	/c c	M) 21	716
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	A STATE OF THE PARTY OF THE PAR	enthe s					

			State of Maryland / Department of Hea  1- State Registrar Certificate of De		Hygiene Reg. No	2004	42294
			1. Decedent's Name (First, Middle, Last)	2. Date (			3. Time of Death
	Physici /Medic		Eun Ki Lee		mber 2	•	12:30A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc	cation of Death	40	. County of Death	
			Randolph Hills Nursing Center Wheaton  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If	Under 24 Hrs. 8. Date of		ntgomery	
	Funeral Director	8		ours Min. (Monti	h, Day, Year)	Coui	
-			Usual Residence of Decedent	oct.	14,15	021   Kore	а
	nyland how		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Ba-f s	cto	Virginia Fairfax Centreville				1 ☐ Yes 2 X No
	with th	Dire	10e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Cour	ntry?
	s 23s	Funerai Directo	14522 Meeting Camp Road 20121  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan	nio Origina (Casaille Van		ted Stat	
	Itam Itam	Į.	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married  12. Was Decedent of Hispat Married  13. Was Decedent of Hispat Married  14. Was Decedent of Hispat Married  15. Was Decedent of Hispat Married  16. Was Decedent of Hispat Married  17. Was Decedent of Hispat Married  18. Was Decedent of Hispat Married  19. Was Decedent o	lexican, Puerto Rican, etc	;.)	Black, White,	
990	urs af	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	pecify:		Specify: Asi	Lan
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural; or Items 23a or 28a-f show other traumatic event, Item Medical Evertical Enter Intelligated.	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done durin	n na most of working	16b. K	and of Business/In	dustry
2	within ene. than "	nple.	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	g most or working			
12	e filed wall Hygier other the		9 Home Maker  17. Father's Name (First, Middle, Last) 18.	Mother's Name (First, Mi		vn Home	
anc	id be fi ental H ked ot ic ever	Be c			idule, ivialder	i Sumame <sub>j</sub>	
Z	should be and Mental amarked o	မ	Nam Chui Baek  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and a	hook Hee Ku Number or Rural Route N	lumber, City o	or Town, State, Zip	Code)
	nd 2 suith ar 27 la r trau		Young Lee, Son 14522 Meeting Co				
ē,	es 1 and 2 of Health f item 27 I r other tra		20a. Method of Disposition 20b. Place of Disposition (Name of	December 2	20c. L	ocation - City or To	
altimore,	Pages nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State  1 ☑ Donation 5 ☐ Other (Specify)  Fairfax Mem.Pk.Cem.	2004	7	irfax, Vi	rgina
Balt	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Therese  M00956  22. Name and Address of Fairfax Meme 9902 Braddon	orial Funera	ıl Home	<u> </u>	
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, su			VA 22032	Approximate
	Fnysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final				Interval Between Onset and Death
	/Medical	1 1	disease or condition resulting in death)  a. Pneumonia  Due to (or as a consequence of):				
	Examiner		Sequentially list conditions b.				
	p #	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
	and and	Examiner	Cause (Disease or Figury that initiated events resulting in death) Last  Due to (or as a consequence of):				
68760,	ficate be executed physician and ts the burial-transit						
687	ficate p phys s the	edicai	d				
Вох			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
	death certi e attending ed for use a	Physician/M	in the past 12 months?  1   Yes   2   7   No   4   Pregnant at time of death   5   Other (specify)		_	Month	Day Year
P.0	that the de led by the a detached t	hys	9 ☐ Unknown 9 ☐ OTINIOWT				
	res tha signed be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in			_	ne cause of death?
orc	law requires as been sign 2 should be	ted	Diabetes Mellitus Type II		1 ☐ Yes 2	□No 3□Prob	ably 4 Unknown
Sec.	e law has b	ompieted			Was an autopsy performed?	24b. Were auto prior to con death?	psy findings available mpletion of cause of
alF	ii <b>clan:</b> The l certificate ha rector, page	O		1 U Y	es 2X No		2□ No
Vital Records,		o Be	examiner? Hospital: Other	Place of Death (Check of		o (30)	
of		-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Nursing Home 5 28d. Desc	ribe how inju		v)
ion	Attending Ph r death, ector: After th by the funeral	atio	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes	2 □ No			
Division	I or Atten after deat Director: in by the	ertification;	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ion (Street ar. r Town, State	nd Number or Rura	l Route Number,
Ō	Hospital or 14 hours afte Funeral Dir tely filled in	O			,		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, description of the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, and due to n, death occurred at the t	the cause(s)	and manner as st place, and due to	ated. the cause(s)
	To the H within 24 To the Fu completel	Med	29b. Signature and title of certifier 22c. License nur	mber	29d. Da	te signed (Month,	Day, Year)
	H 3 H 8		D52261			mber 21,	
A	0/5		30. Name and address of person who completed cause of de th (Item 23a) (Type, Print)		Dece	mucr 419	2004
U	1		/	er Spring, M	D 2091	.0	
	Sta		31. Date filed (Month, Day, Year)    2. Registrar's Signature				
	Registr	ar	DEC 2 3 2004 Keen & Spark				

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			For State Registrar	State of M	aryland /		artment of F		and Me	ntal Hygie	ene 0 0	14	42295
	Disconini		1. Decedent's Name (First, Middle	, Last)					2	Date of Death	Day	Year	3. Time of Death
	Physici /Medic		MARIE		LU	JI				DECEMBE			10.45a M
	Examin		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, o		f Death		4c. County	of Death	
\$£.	- M. 186		Frederick Mem				Freder				Frede	rick	
Ĭ,	Funeral Director		5. Social Security Number 398-09-9446	6. Sex 7. Ag	e (In yrs. last 93	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. A	Date of Birth (Month, Day, ) Pril 30	, 1911	9. Birthpl Count	ace (State or Foreign try)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation					10	Od. Inside City Limits
	Mary fed	jo	Maryland Fre	derick	Mt.	Air	v						1 ☐ Yes 2 No
	1 the	Directo	10e. Street and Number			, , , ,	10f. Zip Code			100	. Citizen of W	hat Count	try?
	3a o	O	14932 Chelsea	Circle			2177	<b>7</b> 1			USA		
	deati	Funeral	11. Maritat Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H f Yes, specify Cuba	lispanic Orig	gin? (Specif	y Yes or No-		- America	
9	after or Ita		1 Never Married 2 Marri	Armed Forces?  1 Yes 2 1  1 Yes, Give	No	i i	1 □ Yes 2 🛣 No	Specify:	, Pueno Aic	an, etc.)		k, White, e	
8	72 hours after death with the Maryland natural', or Itams 23e or 28e-f show Jical Examiner must be neiffied at	d by	3 Widowed 4 □ Divorced	Year or Dates:							Specify:	Whi	te
Maryland 21215-0036		Completed	15. Decedent (Specify only highes		1	(Give	dent's Usual Occup kind of work done	during most	of working	16	b. Kind of Bu	siness/Ind	ustry
12	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5	5+)	IITO. I	DO NOT use retired Seamstre	,			Clothi	na Co	,
2	H T T	e Co	17. Father's Name (First, Middle,	Last)					r's Name (F	First, Middle, Ma			, •
an	D == 0 0	To Be	Chris Christia							ristian		,	
<u> </u>	2 should be and Mental Is markad d aumatic av	Ĕ	19a. Informant's Name/Relations		1	19b. Mailir	ng Address (Street					State, Zip	Code)
S	and 2 salth ar n 27 ls		Erville Koehler	/son			inding Wa				-	-	,
ē,	s 1 au f Hea itam otha		20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of natory or other place	1	Date	1	c. Location -		wn, State
E	Pages 1 an nent of Heal ant: If itam 2 ury or othar		1 Burial 2 Cremation 4 Donation 5 Other (S)	3 Removal from State			ty Cremat		ec 21	,2004	Sykesv	ille.	Md.
Baltimore,	교육단금 .		21. Sign your of Furjeral Service	icepee V	50		2. Name and Addre						
m	Depa Depa Impo any i		atharine	W. Har	Her	1	1802 Libe	rty R	d. L	ibertyt	own, Mo	d. 2	1762
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. INTRI	ne. COAN a consequent	VIAL ce of):	ite inde or dyr						Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and id for use as the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as	a consequen	ce of):							
P.O. Box (	that the death certific ed by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea	ath 3□	Ectopic pregnancy Other (specify)	,			23d. Date Mon	of deliver	y Day Year
Vital Records, P	es pe pe	by	Part II. Other significant condition	ns contributing to death b	ut not resultin	ng in the u	nderlying cause giv	en in Part I.		23e. Did toba	-1		e cause of death?
00	> 0	ompieted								24a. Was an	24b. W	ere autop	sy findings available
Ä	0 - 0	E								autopsy performe 1 ☐ Yes 2 ⅓	d?   de	eath?	pletion of cause of
ita	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place	of Death (C	Check only one)			7
	ys di	ToE	examiner? 1 ☐ Yes 2X No	Hospital:	ent 2 ER/	/Outpatien	t 3 DOA Oth	er: 4 🗆 Nur	rsing Home	5 Residence	e 6 Othe	r (Specify)	
n of	ding Ph h. After th funeral		27. Manner of Death  1 ★ Natural 5 □ Pendin	28a. Date of Inju (Month, Da	ry 28l y Year)	b. Time of Injury	28c. Injur Wor	y at k?	280	1. Describe how	infury occurre	d	
Sio	Attending r death. actor: After by the fune	cati	2 Accident investig	ation			M 1	Yes 2□N	No.				
Division	al or Attend after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ			, farm, str	eet, factory, office		28f.	Location (Streetly or Town,		r or Aural	Route Number,
	Hospital	Ce		- Shadda Tana		4 - 44							
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Aedicai	(Check only 2 Medical one)	g Physician: To the best Examiner: On the basis o and manner sta	f examination	and/or in	vestigation, in my o	pinion, deat	h occurred	at the time, date	and place, a	nd due to	the cause(s)
		Σ	29b. Signature and title of certifier				29c. Licens			29d	. Date signed	(Month, D	ay, Year)
ļ	WJL		LORGE D	HOSPIT			D 00 !	5928	33	DE	CEMBE	R 20	2004
	V 4		30. Name and address of person Richard A		400	W. S	Print) eventh St	. F	reder	ick, MD			
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2	32. Registr	ar's Signature		South :						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:10 Diane Rose Marahrens PM DECEMBER 31 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Center OMBOD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/27/53 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🕅 F 220-46-8987 Maryland Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hyglene. In the Maryland shart if Item 27 ie marked other than "natural", or items 23a or 28a-f show any or other traumatic event, Ire Maricial Examiner manue notified at any or other traumatic event, Ire Maricial Examiner manue notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford 1 ☐ Yes ŽIŽNo Churchville Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21028 3017 Cool Branch Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Brown Henry Marahrens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21028 (Cousin) 3017 Cool Branch Rd., Churchville, MD Sandra L. Eckstein Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Ferris & Co. 1/4/05 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o importent: If any injury or once. Α. West Chester, PA \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P. A
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee uster 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician PANCREATIC PSEUDOCYST /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, physicien Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes 2**X** No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred After t Injury at Work? 1 X Natural 5 Pending 1 □ Yes 2 □ No after death. death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel L 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mella mo January or D 41410 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER F. OSLER DRIVE, MEHTA. M.D., 7601 TOWSON, MARYLAND 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month **Physician** MOYER ELEANOR S. 21, December 2004 0600 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Crows Nest Lane Pines Worcester

9. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Min. Months Hours 1□M 200F Director 6 - 23 - 17PA. 579-20-0668 Usuel Residence of Deceder be filad within 72 hours aftar daath with tha Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County items 23a or 28s-f show traumatic event, the Medical Examiner must be notified a 1 Yes 2 □ No Director MD Worcester Ocean Pines 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number Funeral Crows Nest 21811 Lane 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give ò Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filad withir Department of Haalth and Mental Hygiana Important: If ferm 27 Is marked other than any injury or other traumatic avent the man Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Snyder Bertha Fasold 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Owen Moyer 1 Crows Nest La., Ocean Pines 20c, Location - City of Town, State Spouse 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Berlin, Md Sunset Memorial 21. Signature of Funeral Service Licensee Ullrich Funeral Home Berlin, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Que to (or as a consequence of) Examiner tha burial-transit or Attending Physician: The law requires that the death cartificate be assecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law raquiras triat use weithin 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the a completally filled in by the funeral director, page 2 should be datached. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1X Yas 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No VIII Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Medical Certification: To 4 Nursing Home 5 mesidence 6 □Other (Specify) 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) end manner es stated. 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 9733 31. Dete filed (Month, Day, Year) DEC 2 2 32. Registrer's Signature State CARLAGE . Registrar

				partment of Health and Nertificate of Death	Mental Hygiei Reg.	<b>ZUUU</b> 1277	98
ı	Dhomini		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of D	eath
	Physici /Medio		Melvin L. McKenzie		12 18		AM
}	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	3A1/364y	1.00	Nicomico	
	Funeral Director		1⊠M 2□F	Months Days Hours Min	8. Date of Birth (Month, Day, Ye.		-oreign
			237-46-3965 74  Usual Residence of Decedent		Sept 12,1	1930 NC	
	yland		10a. State 10b. County 10c. City, Town o	Location		10d. Inside City	Limits
	B Mar	ctor	MD Wicomico Salisb	ıry		1 <b>□</b> Yes 2	□No
	ith th	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?	
	ath w 238	ral	27856 Chesterfield Ln.	21801	Ţ	J.S.	
	after death w or Itams 23a	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol><li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 1 ☐ Yes 2 ☐ No Army If Yes, Give 1 Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. In the than "netural", or Itams 23a or 28a-1 show event, I'm Medical Evertiner must be notified at	edt		cedent's Usual Occupation	16h	Kind of Business/Industry	
715	nin 72 n "ne	plet	(Specify only highest grade completed) (G	ive kind of work done during most of work DO NOT use retired)	ring	. Kind of business/moustry	
212	e filed within al Hygiene. I other than ' vant, I' e Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Barber		Self-employed	
b	be filed ntal Hygi nd other evant, L	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	en Surname)	
Maryland	should be ind Menta imarkad imaric ev	To	Rosevelt McKenzie	Maggie	Roberson		
lar	2 sho and Is ma		19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or Rui	al Route Number, Cit	y or Town, State, Zip Code)	
	1 and 1 Health 19m 27			3 Gwynndale Dr., Cl			
Baltimore,	S Join D		20a. Method of Disposition  1  8urial 2  Cremation 3  Removal from State	sposition (Name of rematory or other place)	Date 20c.	Location - City or Town, State	
ij	t. Pa tmen tant: jury		'4 Donation 5 Other (Specify) Md Vete:	cans Cemetery   12/2	7/2004 Hu	rlock, MD	
Bal	permit. Page Department of Important: If any injury or once.		21. Signal of Funeral Price 1	22. Name and Address of Facility  Lewis N. Watson Fu	neral Homo		
	40144		23a. Panti Enter the disease, or complications that caused the death. Do not				
н			shock, or heart failure. List only one cause on each line.		1	Interval Between	en ath
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. PULSECESS	ELECTRICAL	1-1071	VITY.	
	Examiner		Due to (or as a consequence of):	ROTIC CARDIONA		0	
		er	if any, leading to immediate Due to (or as a consequence of):	ROTIC CARDIONA	SCULAR S	1SEASE	
	uted 1 ansit	m in	cause. Enter Underlying Cause (Disease or injury				
Ć	execting and ital-trg	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
38760,	icate be executed physician and s the burial-transit	dlcal	d				
_		-					
Вох	death certifica attending ph I for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery	
	ed fo	sicia	1 Yes 2 No	5 ☐ Other (specify)		Month Day Yea	ir.
0	es that the death cert igned by the attendin be detached for use	Physician/M	9 🗆 Onknown				
ŝ	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the			o use contribute to the cause of deal	
Records,	w requir been si should	eted		2.	1 ☐ Yes	2 No 3 Probably 4 Donk	.nown
Şec	elaw has b	Completed	CONUSESTIVE HEART	FAILURE	24a. Was an autopsy	24b. Were autopsy findings ava prior to completion of caus	
	ding Physician: The law n. After this certificate has E funeral director, page 2 s		CHRANIC DISSTRUTIVE / JUNG	DISTASE	performed? 1 ☐ Yes 2 ☐		
Vital	Attanding Physician: r death. actor: After this certifice by the funeral director,	Be	25. Was case referred to medical examiner?		h (Check only one)		
ot	Phys ral di	2	1 Yes 2 Linko 1 Linpatient 2 ER/Outpa		me 5 Residence 28d. Describe how in		
on	ding F th. After funer	tlor	27. Manne eath  1 Latural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injure		and booting now in	ary occurred	
Division of	Attan r dea actor	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rural Route Number	r,
á	al or A after I Dira d in by	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, Sta	ite)	
	A Hospita 24 hours A Funaral etely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the cause	(s) and manner as stated.	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	ed at the time, date a	nd place, and due to the cause(s)	
	To tha within To tha comple	Σ	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)	
	11/4		Maluny Mi	D-006051	5	12/18/04	
	IVTIA		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	(i)	1	
	100		M. THIMMARAYAMA 614 B	e, Print) EASTERN SHURE	DK 5	GLISBURY MPZI	1824
	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ara de			
	negisti	-31	UF U.Z. 1 ZUU4   J 200000 20	KASTURATE			

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				Pepartment of Health and M Certificate of Death	-	
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  DELORES CATHERINE MUN  4a. Facility Name (If not institution, give street and number)  Washington County Hospital	DEV 4b. City, Town, or Location of Death Hagerstown	2. Date of Death Month Day Year 26 04. County of De Washingt	4 4.50AM
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.		irthplace (State or Foreign Country)
	the Maryland 28a-f show	Director	10a. State 10b. County 10c. City, Town	erstown	10, 02, 444	10d. Inside City Limits 1 ☐ Yes 2X No
9800	72 hours after death with the Maryland matural', or Items 23a or 28a-f show dical Examinar must be notified at	by Funeral	2009 Rosebank Way  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes, Give If Yes, Give Year or Dates:	10f. Zip Code  21742  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I □ Yes 2 No Specify:	incity Yes or No-Rican, etc.)  10g. Citizen of What C  14. Race - Arr  Black, Wh  Specify: Wh	nencan Indian, lite, etc.
nd 21215-0036	filed within Hygiene. other than "	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last)	Decedent's Usual Occupation (Give kind of work done during most of workii iife. DO NOT use retired)  Clerk  18. Mother's Name	ng 16b. Kind of Busines  Retail S  (First, Middle, Maiden Sumame)	,
Maryland	nd 2 should alth and Men 27 Is marke r traumatic	To E	19a. Informant's Name/Relationship (Type, Print)	Mary El Mailing Address (Street and Number or Rura		
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a, Method of Disposition 20b. Place of cometery	7800 Burnside Ave. H. Disposition (Name of properties) ill Cemetery 12-2:	9-04 Hagerstown	Maryland
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury)	Cevebral hom	N. Hagerstown, M	Approximate Interval Between 1 9 mset and Death
. Box 68760,	ie death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1   Ves 2   Temple   Ves 2	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	Divery Day Year
rds, P.O.	law requires that the deatt as been signed by the atte 2 should be detached for	by	9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobacco use con ute t	o the cause of death?
œ e	The ate has page	e Completed	25. Was case referred to redical		autopsy prior to death?  1 Yes 2 No 1 Yes	utopsy findings available completion of cause of
of	Attending Physician: r death. sector: After this certific by the funeral director.	To B	examiner?  1 Y s 2 10 Hospital: 1 Impatient 2 ER/Outp  27. Manyer of Death 1 Natural 5 Pending 2 Accident Investigation  Hospital: 1 Impatient 2 ER/Outp 28a. Date of Injury (Month, Day Yeer) Inj		(Check only one)  ne 5 Residence 6 Other (Spe  8d. Describe how injury occurred	acify)
5	i Sir e	al Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the bast of my knowledge,	death unxument at the time state and place at	8f. Location (Street and Number or R City or Town, State)	r evand
		Medical	(Check only one)  2 Medical Examiner: On the basis of examination and and manner stated.  29b. Signature and title of certifier  Robert Rull MD Resourch Physical	or investigation, in my opinion, death occurre  29c. License number	d at the time, date and place, and during a signed (Monitor)	to the cause(s)
2	Sta Registr		30. Name and address of person who completed cause of death (liter 23a) (T ROBERT BRULL 1459 FOTOWAC AV 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 2 9 2004	G. HAGGESTOWLY	MD 2/742	

Physician /Medical Examiner  DAVID KENNETH MASON  4a. Facility Name (If not institution, give street and number) 4c. County of Death 20529 LOCUST GROVE ROAD  About Month Deay 25, 2004 (1) 4c. County of Death ROHRERSVILLE WASHING.	2300
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. Co	ime of Death
20529 LOCUST GROVE ROAD ROHRERSVILLE WASHING	D730 <sup>™</sup>
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)	
Director 219-60-2679   ¹⊠M 2□F   47 Yrs.   Molitile 243   1865   DEC. 27, 1956   MAH	State or Foreign
Usual Residence of Decedent	
10a. State   10b. County   10c. City, Town or Location   10d. In:    MARYLAND   WASHINGTON   10d. City, Town or Location   10d. In:   MARYLAND   WASHINGTON   10d. In:   MARYLAND   WASHINGTON   10d. City, Town or Location   10d. In:   Maryland   Washington   10d. In:   Maryland   Washington   10d. City, Town or Location   10d. In:   Maryland   Washington   10d. In:   Maryland   10d. In:   Ma	side City Limits □Xes 2 □ No
MARYLAND WASHINGTON ROHRERSVILLE 10g. Citizen of What Country?	
20529 LOCUST GROVE ROAD 21779 U.S.A	
20529 LOCUST GROVE ROAD  21/79  U.S.4  1 Marital Status  1 Never Married 2 Married  1 Never Married 2 No. 1 No. 2	an,
1 Never Married 2 Married 1 Never Married 2 No Specify: WHITE	š
15. Decedent's Education (Specify only highest grade completed)  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)	
15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  17. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  18. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired)  18. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired)  18. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired)  18. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired)	
ET.T/ARETH ATTERNE CNVDER	
HARRY MASON  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, CAROLYN S. MASON, SPOUSE  205.29 LOCUST GROVE ROAD, ROHRERSVILLE, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cametary crematory or other place)  20c. Location - City or Town, State, Zip Code, Cametary crematory or other place)	
CAROLYN S. MASON, SPOUSE 20529 LOCUST GROVE ROAD, ROHRERSVILLE, MD  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Stopped Company or other place)	21779
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory of other place)  20c. Location - City or Town, Si cemetery, crematory of other place)  MT. ZION LOC. GROVE 12/29/2004 ROHRERSVILLE,	
4 Donation 5 Other (Specify)  NTT. Z.ION LCC. GROVE 12/29/2004 ROTRERSVILLES,	Comment I
BAST FUNERAL HOME BOONSBORO, MAKYLAND	21713
shock, or partifal re. List him a suse on each line.	oximate ral Between t and Death
Immediate Cause I Faal	utls
Examiner	
by Gady leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.	
S to se to s	
IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Day   Month   Day	Year
S at 20 at 2	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca	
1 Yes 2 No 3 Probably  24a. Was an 24b. Were autopsy fin	dings available
24a. Was an autopsy fin performed? gentromed? 1   Yes 2   No 1   Yes 2   Mo	
25. Was case reterred to medical axaminer?  40. Place of Death (Check only one)	
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autopsy performed?    Type   Part   P	
Comparison   Com	
1   Yes   2   No   Hospital:   1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)	Number,
1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)	
The state of the s	use(s)
Second of the control of the contr	ause(s)
December 27  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ause(s)
D0058195 December 27	ause(s)

			State of Marylan		ate of Death	wentai my	Reg. No.	04 423	301
Physici	an	1. Decedent's Name (First, Middle, Last)	11.6 /	^		2. Date of Do Month	eath	Year 8 50	
/Medic Examir	cal	4a. Facility Name (If not institution, give si	reet and number)	YEADY.	4b. City, Town, o	1 A	Day 20 th 4c. County	0 /	>
Exami	ici	Alice Byrd Taw		, Home	Crist	ricid	S	OMERSET	
Funeral Director		5. Social Security Number  314-38-1700  Usual Residence of Decedent	7. Age (In yrs.	13 Yrs. Month	der 1 Year If Under 24 Hr ns Days Hours Mir		rth av. Year) 8-31	9. Birthplace (State of Country)	r Foreign
aryland show	_	10a. State 10b. County		ty, Town or Location				10d. Inside Cit	-
r 28a-f	irecto	10e. Street and Number	25 1	MArian 10t.	Zip Code		10g. Citizen of		213 NO
ath with	Funeral Director	27923 PhoENIX	Church k	20	21838			U.S.A	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Timportant: If tien 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examiner must be notified at once.	þ	11. Marital Status  1 Never Married 2 Amarried  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in U, Armed Forces?</li> <li>Mary States</li> <li>Mary S</li></ol>		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 ZNo Specify:	Specify Yes or Norto Rican, etc.)	Specif	ce - American Indian, ck, White, etc.	
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should nd Mei marke matic	٦	19a. Informant's Name/Relationship (Type	•	19b. Mailing Addre	ess (Street and Number or F	Lan 6 Rural Route Numb		State, Zip Code)	
and 2		Margaret UCCreac	14 / Wife	27923 F	hoenix Church		-		
tges 1 nt of He if item or oth		20a. Meth of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	noval from State	Place of Disposition (*)	vame of	Date	20c. Location	City or Town, State	
nit. Pa artmer ortant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Cb	ENEZER U.A.	1. C Ceme Levy	12-24-04	1.1	ion, MD	
permir Depar Impor any ir		Ad S	cocell	Anth	ony E. Ward Hampden An	funeral :	ttomo	ne MD 21	953
Physician		23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one	itions that caused the death cause on each line.	n. Do not enter the m	lode of dying, such as cardia	ac or respiratory a	irrest,	Approximate Interval Betw Onset and D	e ween
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a.		ASCVE					
n #	ner	<u> </u>	Due to (o	r as a consequence o	f):				
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The law requires that the death ce ate has been signed by the attendi page 2 should be detached for use	Completed					24a. Was perfo	an autopsy ormed?	24b. Were autopsy fir available prior to completion of ca of death?	)
	e Cor	OF Was seen referred to reading				13	Yus 2K No	1 Ves 2LIN	No
Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 1	Other:	ath <i>Check only</i> of Home 5 A Resi		er (Specify)	
To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di		27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		how injury occur		
sa after de s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factors/)	ory, office	28f. Location ( City or To	Street and Numb vn, State)	er or Rural Route Numb	oer,
Hospital or 24 hours afte Funeral Dir letely filled in	edical	29a Certifier (Check only one) 12 Certifying Physic 2 Medical Examine	ian: To the best of my know r: On the basis of examinat and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)	
To the within 2 To the comple	ĕ.	29b. Signature and title of certifier	<u> </u>	2	9c. License number			d (Month, Day, Year)	
			V to		P48098	Š	12/	21/2004	
		30. Name and address of person who com Vijay Karumbunatha	•	, , , , , ,	throng Codes	1013 11	1	2101=	
Sta	te	<ol> <li>Date filed (Month, Day, Year)</li> </ol>	32. Registres s Signat	ture		тета, Ма	ryrand ?	7181/	
Registra	ar	DEC 2 2	2004 Decen	1 15 60	30%				

_		_	For State Registrer			Certificate of	Death	R	eg. No.	
	Physicia	an	1. Decedent's Name (First, Middle, La	est)				2. Date of Dear Month 12-20-		3. Time of Death 04:40 A M
	/Medic	al	Carmen Miner  4a. Facility Name (If not institution, gir	re street and number)		4b. City. Town.	or Location of Death	12-20-	4c. County of	
	Examin	er	Suburban Hospita			1	hesda			gomery
	Funeral Director		none	Sex 7. Ag 1 ☐ M 2 🖾 F	e (In yrs. last birthe 73 Yr	Months Bays		8. Date of Birth (Month, Day 11-16-1		. Birthplace (State or Foreign Country) uatemala
	land		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town	or Location				10d. Inside City Limits
	he Mary 8a-f sho	Director	Maryland Montgo	mery	Bet	hesda				1X Yes 2 □ No
	th with the 23a or 2	al Dire	10e. Street and Number 10513 Montrose Av	venue #3		10f. Zip Code 2081	.4	1	og. Citizen of What Guatem	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28a-f show eny injury or other traumatic event, I'm Medical Evancinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:	Ever in U.S. No		Hispanic Origin? (Speban, Mexican, Puerto For SpecifyGuate			American Indian, White, etc. hite
2-0	72 ho netur	eted	15. Decedent's E (Specify only highest gi		16a. D	ecedent's Usual Occu	upation e during most of workin ed)	na	16b. Kind of Busin	ness/Industry
121	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) H	ife. DO NOT use retir ousekeeper	ed)		Self-Emp	loved
7 7	filed v Hygie ther I		6th 17. Father's Name (First, Middle, Las	")			18. Mother's Name	(First, Middle,	<del></del>	o i o y e u
<u>a</u>	lid be ked o ic eve	To Be	Fredrico Lopez				Emelia	Orozco		
ary	shou and M smar	-	19a. Informant's Name/Relationship	(Type, Print)	19b A	Park LO1	at and Number or Rura n Street	i Route Number	; City or Town, Sta	ate, Zip Code)
≥	and 2 ealth m 27 i		Carlos Miner/Son		Ft.	Washingto	on, Marylan	nd 2074	44	
lore	iges 1 or of H		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3			isposition (Name of crematory or other plants			20c. Location - Cit	
늁	artmer artmer ortent injury		' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funera) Service Lice		Gate of		metery 12-		Funeral	Spring, Md. Home, Inc.
Ba	permi Depar Impor eny ir		Manda	Back	4 CC361		St., N.W.			
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a COA	NGEST a consequence of	ARY H	EAST FIBRO	FAIL	URE	Approximate Interval Between Onset and Death
	ecuted and transit	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	· EA	a consequence of	IGE RE	NAL	DISE	ASO	l)
04¢0 68760,	certificate be executed rding physician and use as the burial-transit	Medical Ex	resoning in death) Last	d.	a consequence of					
2 (20) out	death cer e attendir ed for use	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of Month	-
i 2	requires that the een signed by th nould be detache	by	Part II. Other significant conditions	contributing to death b	out not resulting in t	he underlying cause g	oven in Part I.			ite to the cause of death?  Probably 4 Unknown
RMEN i	The law rec tte has bee sage 2 shot	Completed						24a. Was a autops perform	ned? prio	re autopsy findings available r to completion of cause of th?  Yes 2 No
∖. ∏.	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Death	(Check only or	(8)	
A A V	Physician: this certific ral director,	မ	1 ☐ Yes 2 ☐ No	Hospital:			ther: 4 🗆 Nursing Hor			(Specify)
	ding F h. After funera	tion:	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ary 28b. Tir ny Ye <i>ar)</i> Inji	ury W	uryat ork? ⊒Yes 2 ⊒No	28d. Describe h	ow injury occurred	
Division	or Attending after death. Director: Afte in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	28e. Place of In	jury - At home, fam tc. (Specify)	n, street, factory, office		28f. Location (Si City or Town		or Rural Route Number,
MINER	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination and/	death occurred at the or investigation, in my	time, date and place, a opinion, death occurre	and due to the c	ause(s) and mannate and place, and	er as stated. I due to the cause(s)
	To the within 2 To the Comple	Me	29b. Signature and title of certifier	1		29c. Licer	nse number	2	9d. Date signed (/	Month, Day, Year)
	8		) - Cm	w/sa	o, mr	DC	05712	4	12/2	0104
CR	-(1)		30. Name and address of person who		death (Item 23a) (T	une Print)	l9 Executiv Germant	-		
	Sta		31. Date filed (Month, Day, Year)		rar's Signature					
	Registr	ar	DEC 2 3 200	Allen	- 60	DALL!				

State of Maryland / Department of Health and Mental Hygiene $2 \bigcap \bigcap I_4$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20<u>04</u> Month 1 2 Year **Physician** 4:40 am 20 Eva Barnes McPhail /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George Thomas Moore Nursing Center Hyattsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖫 F Yrs. 90 238 20 7805 11/04/14 Director Farmville, NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be rivitiled at 1 ☐XYes 2 ☐ No Hyattsville P.G. Director Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4922 Lasalle Road USA 20782 or items 23s death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene "natural", or ites Important: If Item 27 is marked other then "natural", or ites any injury och ther traumatic event, the Medical Examinan 1 Tes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Register Nurse Private 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be Julia Tyson ٥ Clarence Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Relationship (Type, Print) 4340 West Perry St. Farmville, NC 27825 Dupree Cousin Evangline 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/27/04 Farmville, NC 4 Donation 5 Other (Specify) Sunset Memorial 22. Name and Address of Facility
Joyner's Mortuary
4310 Wallace St Farmville, NC 27825 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscherohe Cardinasular Distase **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physician P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year jo Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. page 2 should be 1 Yes 2 No 3 Probably 4 2 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 ENO or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 🖃 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor QUEENSBURY ROAD HYGITS WILL MD 20781 ONE mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 21 2004 Registrar

		Please						re All Copies	_	
		1 - State	State of Ma	arylanu /	•	ficate of		and Mental Hy	Reg. N2 0 0 4	42304
	71	Registrar  1. Decedent's Name (First, Middle, La	st)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Doutin	2. Date of Dea	ath	3. Time of Death
Physic /Med		Lucia	2	M.	me	DAN	IFL	OECEIN C	Day Year	4 0605 M
Exami		4a. Facility Name (If not institution, give				b. City, Town, o			4c. County of Dea	th
			IER HOSI	PITAL		CHES	1ER	70WN	KER	7
Funeral Director		5. Social Security Number 6. S 054-32-3726	Sex 7. Ag 1 □ M 2 🖫 🖡	66 (In yrs. last		f Under 1 Year Months Days	Hours	Min.  8. Date of Birt (Month, Pa	y, Year) 38 Nev	thplace (State or Foreign ountry) York
		Usual Residence of Decedent						Journ 0,	1 2500 INEW	TOLK
rrylan show	<u>.</u>	10a. State 10b. County		10c. City, To	own or Locat	ion				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Pe Mg	ecto	Maryland Ken	<u>t</u>	W	orton				40. 000 - (140-10	
id K I K 15-0050  filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or Items 23a or 28e-f show	Funeral Director	10e. Street and Number 11180 Oak Lane				10f. Zip Code 2167	78		10g. Citizen of What C USA	ountry?
death ms 23	eral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Wa			gin? (Specify Yes or No , Puerto Rican, etc.)		
after or Ite		1 Never Married 2 Married	1 Yes 2 If Yes, Give	No		es, specify Cubi	an, Mexican Specify:	i, Puerto Hican, etc.)	Canaifu	
aral;	d by	3 Widowed 4 Divorced	Year or Dates:							lack
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2 sho s and is ma	3)	19a. Informant's Name/Relationship		1	_			or or Rural Route Number Norton, MD	er, City or Town, State, 21678	Zip Code)
ite, Mal yiallu ZIZ s 1 and 2 should be filed withi if Health and Mental Hygiene. item 27 is marked other than other traumatic event, IDSM	1	Ernest Robinson/	promer	20b. Place	of Dispositi	on (Name of	- 1	Date	20c. Location - City or	Town, State
Pages nent of nnt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci				ory`or other plac		er 12/20/20		
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		2 a. Part1. Enter the disease, or com shock, or heart fair we. List only	plications In t caused one cause on each li	d the death. D	o not enter t	he mode of dyir			4	Approximate Interval Between
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attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea	ath 3 □Ec	topic pregnancy	/		23d. Date of de Month	livery Day Year
the dy the ached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	t inno or dodu		(3,000,11)				
The COLOS, P.O. BOX 001  The law requires that the death certificate the has been signed by the attending physogo 2 should be detached for use as the	by Pł	Part II Other significant conditions	contributing to death b	out not resultin	g in the unde	orlying cause giv	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
v requires been sign		My of mu	cord of	nder	noie	& Cag	100	- 1 k 101	res 2.12No 3□P	robably 4 Unknown
5 8 8 6	Completed	S/P rese	ction of	non	elill	e reco	wit	ender 24a. Was	sy prior to	utopsy findings available completion of cause of
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OI VITAL Physician: rthis certifica	Be	25. Was case referred to medical examiner?	Hospital:	(/-		aC DOA Oth		of Death (Check only o		
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To the Hospital or Attend within 24 hours after death To the Funeral Director: 4 completely filled in by the fi	edical			of examination				d place, and due to the the occurred at the time,		
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F \$ F 0		V 1411.44	im	MD		0:	2/3/	3	12/19/0	4
		30. Name and address of person who	completed cause of c	death (Item 23	a) (Type, Pri	1		n 1 0	_ 1.7	
		KINK WELL	1,415	Was	lingt	on Ho	4.,6	hestertor	on, IND	21620
S Regis	tate trar	31. Date filed (Month, Day Year)	2 2004 Registr	's Signature	1.	books				
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			1 - For State Registrar		aryland / Depa		Health and M		ne 2001	42305
	Physici	an.	1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	Nicholas Andr 4a. Facility Name (If not institution, giv 3806 Wine Road	e street and number)		Westm	or Location of Death		18 2004 4c. County of Death Carroll	11:40 aM
	Funeral Director		5. Social Security Number 6. S 217-27-7905  Usual Residence of Decedent	ex 7. Ag Min 2□F	e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea March 27	9. Birthp Cour 1987	place (State or Foreign htry)
	Maryland a-f show	tor	10a. State 10b. County  MD Carro	11.	10c. City, Town or Lo Wes	cation tminster			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ Xo
	th with the 23a or 28a	al Director	10e. Street and Number 3806 Wine Road			10f. Zip Code 21	158	10g.	Citizen of What Cour	ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examinar mast be notified at	by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No (	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ Who	Hispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W.	an Indian, etc. hite
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	1 and 2 sho Health and I lam 27 Is ma		19a. Informant's Name/Relationship ( M/M Andrew McKend  20a. Method of Disposition			Wine Ro	ad Westmi	inster, MD		
Baltimore,	Page nent c ant: If ary or		1 ☐ Burial 2 ③ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Fundamental Service Lieux	y)	Carroll	matory or other pla Cremation	n, Inc 12,	/22/2004	Hampstead	
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760,	tificate be executed  Medical  By physicien and as the burial-transit	dical Examiner	shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	a consequence of):  a consequence of):  a consequence of):	n Sy	mdis	ne		Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	:y		23d. Date of delive Month	ory Day Year
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Vital	Physician: this certificated ral director,	Be	25. Was case referred to medical examiner?	Hospital:		O#	han	Check only one		
of	ding After funer	atlon; To	1 Yes 2 No  27. Manner ath 1 Urai 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da		f 28c. Inju	4   Isuising Ho	me 5 Serisidence 28d. Describe how in	6 ☐ Other (Specify jury occurred	v) 
Division	Dir	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injuding, et	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	the Hospital hin 24 hours a tha Funaral hpletely filled	Medical	(Check only 2 Medical Examons)	ysician: To the best niner: On the basis of and manner sta	of my knowledge, deat f examination and/or in ated.	vestigation, in my	opinion, death occurr	ed at the time, date a	ind place, and due to	the cause(s)
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	2			OMAN	leath (Item 23a) (Type,	Print)	1 PKW	AY B	AL7 2	(SIS)
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# George IV ixon December 19,2004

Certificate of Death  Physician  See A Congress of Care See A Congre				Please		nd / Departme	le Ink. Assure All nt of Health and Me	-	•	1 100	0.0
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Source Security Williams Company of the Company of				GEORGE	N. N:	X01)		Decem	ber19:	2004 9 19	eath 3
To, Silver and Monther Silver of State Silver	لر	Funeral	ner	5. Social Security Number 6. S 216-14-2064	119 Regiona Sex 7. Age (In yrs.	last birthday) If Und	er 1 Year If Under 24 Hrs. S Days Hours Min.	Stoury 3. Date of Birth (Month, Day, Yes	W, C	Birthplace (State or F	
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17. Final Parker's Name (Final, Michige, Last)   18. Mother's Name (Final, Michige, Capt)   18. Mother's Name		23a c	la l	11974 Edget		E	21853		U.S.	A	
17. Final Parker's Name (Final, Michige, Last)   18. Mother's Name (Final, Michige, Capt)   18. Mother's Name	020	urs after dea al', or Itams Examinar in	2	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ No If Yes, Give			ify Yes or No- ican, etc.)	Black, W		
The property of the property o	1215-0	vithin 72 ho ne. hen "natur e Medical I	mpleted	(Specify only highest green Elementary/Secondary (0-12)	de completed)	(Give kind of v	rork done during most of working use retired)	7			~5
206. Place of Disposition Name and Accesses of Sealthy 206. Hand of Disposition Object 19 206. Location - City of Town State 19 8 banal 2   Certainton 3   Removal from State 19 9 banal 2   Certainton 3   Certainton 3   Removal from State 19 9 banal 2   Certainton 3   6.4	filed v Hygie ther t		, 0		LA				TUGUSTIC	ري	
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The complete of the part of		5 % OF F		Mattie Johnson	· lwife	30777 [	livision ST. P	incess,	Anne.	NO 2189	53
23a. Part I. First red disease for complications that fassed the death. Do not writer the mode of dying, such as cardiac or respiratory arrest, Approximation of clause (Final disease or condition).  Physician (Modical Examiner)  Physician (Modica	more	Pages ent of st: If it		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. F	Place of Disposition (Nemetery, crematory of	ame of other place)	Date 20c.	Location - City	or Town, State	
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Cause (Disease or injury to the complete of the cause of	1	/Medical	<b>T</b>	disease or condition	a. End SA  Due to (o	or as a consequence of	Chumer's	Deme	ulia	5 7	aun Ls
The state of the second section of the second of the secon		certificate be executed Iding physician and Use es the bunal-transit	क	if any, leading to immediate cause. Enter Unicarying Cause (Disease or injury that initiated events	C						
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25. Was case placered to medical examiner?)  10 yes 2  No  25. Was case placered to medical examiner?)  10 yes 2  No  26. Place of Death (Check only one)  27. Manner of Death 1  Norsing Home 5  Residence 6  Other (Specify)  28. Date of Injury M 1  Yes 2  No  28. Date of Injury M 1  Yes 2  No  28. Date of Injury M 1  Yes 2  No  28. Date of Injury M 1  Yes 2  No  28. Place of Injury At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  28. Place of Injury - At home, farm, street, factory, office  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier one)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	ecords	aw requires l s been sign 2 should be		Parkinson.	Diseas	-		24a. Was an aut performed?		available prior to completion of cause	•
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1 Natural 2   Accident 3   Suicide 4   Homicide   See Piace of Injury - At home, farm, street, factory, office   See Piace of Injury - At home, farm, stre	6	Phys this raldi			1 □ Inpatient 2 ■		TOA   4   Nursing Home			ecify)	
29a. Certifler (Check only one)  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and title of certifler (Check only one)  29c. License number (Check only one)  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)	5	After fune	흲	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury		a. Dosonbo now inj	ary occurred		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 2180)  31. Data filled (Month Day Year)		the Hospita in 24 hours the Funeral ipletely fille	edical	(Check only 2 Medical Exan	niner: On the basis of examinat	wledge, death occurre tion and/or investigatio	d at the time, date and place, and n, in my opinion, death occurred	d due to the cause( at the time, date a	(s) and manner nd place, and d	as steted. ue to the cause(s)	
GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MO 21801	)	vith To 1	2	Tregenih!	Bellow	ha.	D 29505	*			
			1				A mar Pill day ton had now new .	1 4 4	-1- 3-	D m 100	
		Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture .	MOCKET DK.	MLISIBU	KY, M	V 2180	L

			For State Registrar	State of M	aryland		artment tificate				F	Reg. No.	711111	42307
	Physici /Medic		Decedent's Name (First, Middle, La     Robley Derricksc		ns					1	2. Date of Dea Month Dec.	Day		3. Time of Death  11:30a M
>	Examir		4a. Facility Name (If not institution, give				4b. City, To	own, or L	ocation of	Death		4c.	County of Dea	
			26 Greenway Avenu		io (In um 1	ast birthday)	Pocon		City		Data of Bird		rcester	
	Funeral Director			7. A9	91	Yrs.		Days	Hours	Min.	B. Date of Birt (Month, Pa) 9/30/1	913		thplace (State or Foreign puntry) ryland
	yland how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Ba-f s	Director	MD Worceste	r	Poc	omoke	City							1Ã Yes 2 No
	with the or 2	Dire	10e. Street and Number				10f. Zip C					10g. Citi	zen of What Co	ountry?
	leath ns 23	Funeral	26 Greenway Ave	nue 12. Was Decedent	Ever in U.S	S. 13. \	2185 Was Decede		panic Origi	in? (Spec	ify Yes or No-		USA 14. Race - Ame	erican Indian
336	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "neturel", or Items 23a or 28e-f show aumatic event, the Micical Exeminer must be notified at	by Fun	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 □ 4 es 2 □ If Yes, Give Year or Dates:		ł	fYes, specify 1 ☐ Yes 2[		Mexican, Specify:	Puerto R	ify Yes or No- can, etc.)		Black, Whit	
5-0036	72 ho	ted	15. Decedent's E (Specify only highest gra			16a. Deced	lent's Usual	Occupation done du	on	of working		16b. Kir	nd of Business	
2121	d within glene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work DO NOT use les	retired)	mig most c	or working		R	Retail	
•	be filed ital Hygird of other event, I	Be	17. Father's Name (First, Middle, Last								First, Middle,		Sumame)	
<u>\S</u>	should be and Mental marked o umatic eve	2	Luther G. Parsons  19a. Informant's Name/Relationship (	·		10h Mailie	Address (				Sturgi		r Town, State, 2	7.0-1-1
Ma			Richard D. Parsor									-	MD 218	
ē,	s 1 and f Health item 27 other to		20a. Method of Disposition		20b. Pl	ace of Dispo				Da	_		cation - City or	
altimore,	<b>6</b> 0	3	1 ☑Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special							2/27/	2004	Poco	omoke C	ity, MD
Balt	permit. Page Department Important: fl any injury o		21. Signature of Funeral Service Lice	1500 20 sm		Hc	116way	AddMes	i Facility	Fune	ral Ho	me,		
760,	Care be executed hysician and hysician and the buriar-transit the buri	ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enser underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as  b. Due to (or as  c. Due to (or as	a consequ a consequ	ience of):	Arte	ry	Dis	عم	se_			Interval Batween Onset and Death
O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel	death 3□	Ectopic preg Other (spec					2	3d. Date of deli Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	lting in the ur	derlying cau	se given	in Part I.			baccous		the cause of death?
Vital Records,	The law re	Completed									24a. Was a autops perfor	sy med?	24b. Were au prior to death?	itopsy findings available completion of cause of
ıta		Bec	25. Was case referred to medical examiner?								Check only or	18)		
	Physic this corral dire	ဥ	1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatie		ER/Outpatient		Other	4 🗆 Nursi				□Other (Spec	cify)
Division of	ding l	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		ry y Year)	28b. Time of Injury	28c	: Injury at Work? 1  Yes	t s 2 ⊡No		d. Describe h	ow injury	occurred	İ
Š	spital or Att ours after di nerel Direct filled in by t	Certification:	3 Suicide 6 Could not b		ury - At hor c. (Specify)	me, farm, stre	et, factory, c	office		28	f. Location (S City or Town	treet and n, State)	d Number or Ru	iral Route Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysicien: To the best niner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred at estigation, in	the time, my opin	date and pion, death	place, and occurred	d due to the c at the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s)
,	Tot With Com	Σ	29b. Signature and title of certifier	M)				icense n	umber Lj22	L	2		signed (Month	
1	H.		30. Name and address of person who 1604- Mark	et St.	eath (Item)	)23a) (Type, I	Print)	e;	M	11)	218	55:	1	
	Sta Registr		31. Date filed (Month Day, Year)	32. Pegistr.	ar's Signati	ure	adi							

	-	1 - For Stete Registrar	State of Ma		artment ertificate				R	eg. No.2	004	42200
Physicia	n	1. Decedent's Name (First, Middle, Last, ROBERTA J. PAR							2. Oate of Dea Month	Day	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, give			4b. City, T	Town, or	Location of	f Death	1) ecombi	T - 7	2004 ity of Death	1030 AM
Examin	21	WASHINGTON COL		TAL			GERST				HINGTO	N
Funeral Director		5. Social Security Number 6. Sec. 232 - 54 - 3408		(In yrs. la <i>st birthd</i> a) 68 Yrs.	/) If Under 1 Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day 10/3/19		9. Birthr Cour WEST	place (State or Foreign htry) VIRGINIA
land Dw	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	ocation						1	0d. Inside City Limits
8a-f sh	ector	WV BERKEL	EY	MARTI	NSBURG							1 XX Yes 2 □ No
h with th	Dire	10e. Street and Number 503 BACHMAN LA	\NE		10f. Zip (	Code 25401	L		1	0g. Citizen o USA	f What Cour	ntry?
72 hours after death with the Maryland naturel, or Items 23a or 28a-f show diest Examiner must be natilised at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decede		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		ace - Americ ack, White, ify:	
I within 72 hou jiene. r then "nature ir e Medical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i> College (1-4or 5+	(Giv	edent's Usual e kind of work DO NOT use	k done d e retired;	urina most	of workin	ng	16b. Kind of	Business/In	dustry
be fill ital H id oth	To Be Co	12 17. Father's Name (First, Middle, Last) ROBERT P. MACE			HOMEMA	KER			(First, Middle, I		ame)	
s 1 and 2 should f Health and Mer item 27 is marke other treumetic		19a. Informant's Name/Relationship (Ty MARSHALL E. PARKE		50	3 ВАСН	IMAN	LANE	, MAI	Route Number RTINSBUI	RG, WV	25401	<u> </u>
nit. Pages 1 artment of Hortent: If ite		20a. Method of Disposition  1 XX Burial 2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)		PLEASANT	TTEW MEM ARDENS	iory	2	ECEME 29, 20	3ER 004	20c. Location MARTINSE	BURG, W	V
Departition Depart	ł	21. Signature of Funeral Service Licens	Biow	1	22. Name and BROWN FU	Addres INERAL	s of Facility _ HOME ,	P.O.	BOX 821 MARTII	327 W.	KING S W 254	STREET, 02
Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused to cause on each line	he death. Do not e	nter the mode	of dying	, such as o	eardiac or	respiratory arr	est, carolio	l	Approximate Interval Between Onset and Death
/Medical Examiner	-	resulting in death)  Sequentially list conditions, if any leading to immediate	Acut	consequence of):	ironic	re	nal	fail	ure	inda	rct	1 wet.
cate be executed hysician and the burial-transit	Ж	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	Type	Ic	tiabe	tes	mellitu			months.
ficate be physicia s the bur	edicai	(	. Ischei	ric C	serctio)	mej.	spath	ry				years.
ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pre □ Other (spe						ate of delive	ory Day Year
w requires that the de been signed by the a should be detached t	þ	Part II. Other significant conditions con	ntributing to death but	A		use give	n in Part I.					ne cause of death?
The te had age	Completed	Asthmo Hyperte						_	24a. Was a autops perform	y ned?	prior to cor death?	psy findings available inpletion of cause of
slcien: certifica rector, p	Be	25. Was case referred to dical					26. Place	of Death	(Check only on			
hys this al dir	ition: To	1 ☐ Yes 2 ☒ No	1 X Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpatie 28b. Time Year) Injury		Sc. Injury Work	4 🗀 Nur	2	ne 5 🗌 Reside 8d. Describe ho			<i>'</i> )
	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory,	office		2	8f. Location (St. City or Town		ber or Rura	l Route Number,
Hospi 4 hou Funer ely fill	edicai C	29a. Certifier 1 Certifying Physical (Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and/or i	th occurred a nvestigation, i	t the time	e, date and inion, death	place, ai	nd due to the ca d at the time, da	tuse(s) and mate and place	nanner as st , and due to	ated. the cause(s)
To the To the complet	ž	29b. Signature and title of certifier			29c.	License			25	d. Date sign		
/		1 Canda	eur 1	ND		D	4710	1		12/	25/2	004
H'S		30. Name and address of person who co	MD	WASHII	, Print) VG TON	Co	UNTY	/ HO	SPITAL	. HAGE	RSTOWN	I, MD.
Stat Registra		31. Date filed (Month, Day, Year) DEC 28 21	32. Registrar	's Signature	Inertes		,					

			For	Sta								ental Hy		Legible	7 <b>-</b>
			1 - State Registrar					rtificate					Reg. Nd	2001	+ 42310
	Physici	an	Decedent's Name (First, Mide	fle, Last)								2. Date of D Month	Da		N.A.
	/Medic	cal	I1 Young Pa		and number)			4b. City.	Town, or	Location o		Decemb		2, 200 County of D	
	Examir	ier	Randolph Hill	-					aton					ontgom	
	Funeral		5. Social Security Number	6. Sex 1 1 M 2			last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9.	Birthplace (State or Foreign Country)
	Director		231-25-6701 Usual Residence of Decedent			87						Aug.	5,19	17	Korea
	aryland show	<u>.</u>	10a. State 10b. Count	У		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	the Ma	Director	Maryland Mont	gomery		Si1	ver Sp	ring 10f. Zip	Code				10a Cit	tizen of What	1 Yes 2 No
	3a or	i Dir	13128 Kara Lan	9				209							
	ems 2	iner	11. Marital Status	12. Wa	s Decedent	Ever in U.	.S. 13.		lent of Hi	spanic Orig	gin? (Spe	cify Yes or N Rican, etc.)			merican Indian, /hite, etc.
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show the Medical Exercities must be trofilled at	Completed by Funeral	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorce	rried 1 [	Yes 2 7 es, Give X ar or Dates:	No		1 ☐ Yes 2		Specify:		, , , , , ,		Specify:	
21215-0036	2 hour	ted t	15. Decede	nt's Education			16a. Dece	dent's Usua	I Occupa	ation			16b. K	and of Busine	
215	ithin 7	npie	(Specify only high Elementary/Secondary (0-12)		ilege (1-4or	5+)		kind of wor DO NOT us		iuring most )	r or workii	ng			
	filed w Hygier thar ti		17. Father's Name (First, Middle	, Last)			Me	rchan	t	18. Mothe	r's Name	(First, Middle	-	etail	
lan	fental fental rked o	To Be	Kyu Hyun Park								Sin				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department if item 27 is marked other than "naturel", or items 23s or 28s-1 show importent: if item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other treumatic event. Its Medical Exact natural be putilled at Once.		19a. Informant's Name/Relation	ship (Type, Pri	int)									or Town, Stat	
	1 and Health em 27 ther to		Sam Park, Son  20a. Method of Disposition			20b. P	lace of Dispo	sition (Nam	ne of	1	D	ate	20c. L	MD 209	or Town, State
Baltimore,	Pages ent of nt: # it ry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	. 3 ∭Remova Specify)	ıl from State	6	emetery, crei rfax N	matory or of	ther place		ecem1 20	ber 29	,		Virginia
alti	permit. I Departm Importer any inju		21. Signature of Funer, I Service			гал						neral 1		IIIax,	VIIEIIIIa
B	20529		1-1	1 me		0956	199	902 Br	adde	ock Re	oad	Fairt	ax, V	VA 220	7-1-
			23a. Part1. En er the di ease, shock, or heart failure. Li Immediate Cause (Final	or complications st only one caus	s that cause se on each l	d the deati ine.	n. Do not en	er the mode	e of dying	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		cute H		Attacl	ζ							Within 1 Hr. Several
8	Examiner		Sequentially list conditions	b. A1	Lzheim	er's	Diseas	se							Months
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	< _	Due to (or as		uence of):								1 ** 1-
,	execut n and ial-trar	Examiner	that initiated events resulting in death) Last	0.	neumon Due to (or as		uence of):						_		1 Week
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cai		d					_						
39 x	eath certifical attending phy I for use as th	/Med	IF FEMALE:	220 16 1	es, outcome	of progna									
Вох	Jeath c attend	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	10	Live birth Pregnant a	2 Feta	Ideath 3[	Ectopic pro						23d. Date of Month	delivery Day Year
P.O.	that the de led by the a detached f	Physician/Med	9 🗆 Unknown		Unknown										
	ires tha signed I d be det	b	Part II. Other significant condi	tions contribution	ng to death t	out not res	ulting in the u	nderlying ca	ause give	en in Part I.		1	Yes 2	_	e to the cause of death?  Probably 4 Dunknown
Records,	w require been signal	ietec										24a. Was		Λ	autopsy findings available
Re	sician: The law certificate has l irector, page 2 s	Completed										auto	opsy ormed?	prior	to completion of cause of
Vital	cian: ertifica ector, p	Be C	25. Was case referred to medic examiner?	<u> </u>							of Death	(Check only			33 22/10
of \	Phy this al d	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospita 28a	l: 1 ☐ Inpati . Date of Inju		ER/Outpatier		_	4 K HADI		ne 5 🗆 Res 8d. Describe		6 Other (S	pecify)
ion	ding After fune	ation	1 X Natural 5 ☐ Pend		(Month, Da	y Year)	Injury	м	Bc. Injury Work	(?` Yes 2 □ N		.04. 0000100	11011 11110	ry obbaniou	
Division	or Attendi ifter death. Director: A in by the fu	Certification:	3 Suicide 6 Coul-	d not be mined 28e	. Place of In building, et	jury - At ho	ome, farm, sti	eet, factory	, office		2	28f. Location City or To			Rural Route Number,
	pitel o		CO. Cartifica 157 Cartif	ing Physician	To the best	of my line		-	- 4 4 1 - 4 4		-			\	
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	Medical	29a. Certifier 157 Certify (Check only 2 Medical one)	ing Physician: Il Exeminer: O ar	n the basis of nd manner st	of examina	tion and/or in	vestigation,	in my op	ie, uate and pinion, deat	u piace, a th occurre	ad at the time	date and	, and manner d place, and d	as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifi	er	,		_	29c	. License	number			29d. Da	te signed (Mo	onth, Day, Year)
)				?.e. C	2				0021	033			Dece	mber 2	2, 2004
K	(3)		30. Name and address of person Byoung K. Lee						Sil.	ver C	nrin	g, MD	2000	6	
	Sta		31. Date filed (Month, Day, Yea	r)	32. Registi	rar's Signa	ture		OTT	ACT 9	hr TII	5 EID	ZU3U!	U	
	Regist	rar	DEC 2 3 2	UU4	leve	J.K.	Span	W							

			For State Registrar		rland / Depa		Health and	Mental Hygie	ne2004	42311
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		ELFRIEDA MAR					DECEMBE	R18,2004	
	Examin	er	4a. Facility Name (If not institution, give s				or Location of Dea		4c. County of Dee	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth		thplace (State or Foreign ountry)
	Director		135-16-7412	M 2 📉 F 💮 8	39 Yrs.	Months Days	Hours Mir	April 2,		
	Marylan	tor	10a. State 10b. County Maryland Montgomer		c. City, Town or Le Sandy Spr					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number 18131 Slade School	1 D.4		10f. Zip Code 208	60	10g.	Citizen of What Co	ountry?
	death rns 2: rnus	nera		2. Was Decedent Ever	r in U.S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - Ame	
036	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Exatrans must be notified at	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2x No		no Hican, etc.)	Black, White	White
Maryland 21215-0036	hin 72 ho s. nn "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)			upation e during most of wi ed)		o. Kind of Business	
d 21;	Hygi other	Ве Сош	8th 17. Father's Name (First, Middle, Last)		Funer	al Assis		ame (First, Middle, Mai	uneral So den Sumame)	ervice
<u>lan</u>	uid be Vental rked c	To B	Herman Zeltner				Justin	e Rhorig		
lan,	it. Pages 1 and 2 should be riment of Health and Mental riant: If item 27 is marked hillury or other traumatic even.		19a. Informant's Name/Relationship (Typ			,		Rural Route Number, C		
	1 and Health em 27 ther t		Elizabeth Fick- Dat 20a. Method of Disposition		20 / 10 20b. Place of Dispo cemetery, cre			thersburg,	MD 20882 Location - City or	
ğ	To me of		1 ☑Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	Billoval Ironi State			l l	/21/2004 1	·	
Baltimore,	permit. Pa Depertmen Important: any injury		21. Signature Funeral Service License					nes-Rinald:		
m	Depermine Timbo		Jendy E	NI	1	1800 New	Hampshi	re Ave. Sil	lver Spri	ng, MD 20904
	Physician		23a. Part1. Énter the disease, or complic shock, or heart failure. List only on Immediate Caustier.	e cause on each line.						Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co		IC DEA.	ry DATI	(0)		DAYS
	Examiner	10	Sequentially list conditions, b	DUSPHA Due to (or as a co	AGIA					DAYS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	BACTER		JENM OF	SIA			DAYS
oʻ	be executed sician and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a co						
68760,	# × #	dicai	Cd							
Вох	The law requires that the death centificate tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death 3	□Ectopic pregnan	су		23d. Date of de Month	livery Day Year
0	that the de ed by the detached	Phys	9 Unknown	9□ Unknown						
	w requires that been signed I should be det	ed by	Part II. Other significant conditions con CONGESTIVE	tributing to death but no	•	inderlying cause g	iven in Part I.	23e. Did tobac		o the cause of death?
Vital Records,	The law reate has be page 2 sho	Completed by						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one)		
<u>\</u>	Physic this or	၉	1 □ Yes 2√ No	ospital: 1   Inpatient	2 ER/Outpatie	nt 3 DOA		Home 5 Residence		cify)
o	ding h. After funer	tlon;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	W	uryat ork? ]Yes 2 □ No	28d. Describe how i	nlury occurred	
Division of	i or Attandin after death. I Director: Aft d in by the fur	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st			28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifical completely illied in by the funaral director.	edical Ce	29a. Certifier Certifying Phys	ician: To the best of m	amination and/or in	h occurred at the westigation, in my	time, date and place opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	o the omple	Med	29b. Signature and title of certifier	and manner stated			ise number		Date signed (Mont	
•	/		> Sm st	AFF PHYSI	CLAN	D	42046	Dec	Eughe 1	8. 2004
	5		30. Name an address of person who could CHACE BROOKE HUFFA	mpleted cause of death	(Item 23a) (Type,	Print)	0	0	Maria estados e	
			GRACE BROOKE (+VFFA 31. Date filed (Month, Day, Year)	MD, M.D. 18	100 SLAD	E SCHOOL	KOAD JA	NOY SPRING	MARY	LAND 20860
	Sta Registi		31. Date filed (Month, Day, Year) <b>NFC. 21</b> 2004	32. Hegistrar's	Signature	Sparks		•	1	

		•	For State Registrar	State of Marylar	nd / Depa	artment of H	ealth and M Death	Re	g. No.	
	Physicia	an	Decedent's Name (First, Middle, Last)		NA DD 17			<ol><li>Date of Death Month</li></ol>	n Day Yea	
	/Medic	al		ETTY MAE F	PARRY			DEC. 1	8, 2004	9:35 P <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give stre CARROLL HOSPITA				Location of Death		4c. County of De	
			5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director			-F3-F	77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 7 / 5 / 1 9	Year) 927 MA	Country) ARYLAND
			Usual Residence of Decedent						, , , , , , , , , , , , , , , , , , , ,	
	show	_	MD. 10b. County CARROLL		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	8e-f	ecto					<del></del>	1/	On Chinan of Minat	
	a or 2	ក់	10e. Street and Number 439 MAPLE AVE.			10f. Zip Code 21157	7		og. Citizen of What USA	Country
	ns 23	era		Was Decedent Ever in U	J.S. 13.		ispanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-		merican Indian,
(0	r iten	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No				Rican, etc.)	Black, W	
Š	ral', c	1 by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2Ã No	Specify:		Specify: W	HITE
Ş	72 h natu	ete	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of working	ng 1	16b. Kind of Busine	ss/Industry
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. I do ther then "natural", or items 23a or 28e-f show of other then "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		CHINE O	•		SHOE FA	CTORY
	Hygi Hygi ther int,		17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	faiden Surname)	
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 Is marked of any injury or other treumatic events.	To Be	HARR		RNHART		EDNA		HALEY	
Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (Type) EDGAR E. PARRY	- SON			and Number or Rura CER RD			PA. 17340
	1 and Healt sm 2		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		ate 2	20c. Location - City	or Town, State
JOL	ages ant of it; if it y or o		1 ☑Burial 2 ☐ Cremation 3 ☐ Rem `4 ☐ Donation 5 ☐ Other (Specify)	noval from State EVE	cemetery, cre. RGREEI	matory or other place MEM.GA	RDENS 1	2/22/04	4 FINKSE	BURG, MD.
Baltimore,	artine corten injur		21. Cignature of Financial Service Licensee	J	2:	2. Name and Addres	ss of FacilityFLE	TCHER E	FUNERAL	HOME
ä	permi Depa Impo any i		1911							ID. 21157
			23a. Part1. Enter the disease, or complica shock, or beart failure. List only one	tions that caused the dea cause on each line.	th. Do not en	er the mode of dyin	^		est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Massive	Cereb	10 Vasculos	/ Acci	dent		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
		į.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):					
	uted I Insit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c.		,,.					
oʻ	sician and burial-transit	Еха	resulting in death) Last	Due to (or as a conse	quence of):					
68760	2 2 2	Ical	d							
39 )	entifica ling ph e as th	Med	IF FEMALE:							
Вох	death certifica attending ph I for use as th	Physician/M	in the past 12 mg/sths?	. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3[	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of o Month	delivery Day Year
P.O.	that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	dealii J					
ls, P.	res that the igned by th be detache	by Ph	Part II. Other significant conditions contri	buting to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	w requires been sign should be							1 ☐ Ye	s 2□No 3□	Probably 4 Munknown
Record	8 S CA	Completed						24a. Was ar autopsy	24b. Were	autopsy findings available to completion of cause of
Ä		E O						perform	ned? death	?
Vital	Physician: T this certificet ral director, pe	Be	25. Was case referred to medical examiner?			100	26. Place of Death	(Check only one	9)	
of	hys this al di	To.	T Tes 2 No		ER/Outpatie		4 Later and Thor		nce 6 Other (S	pecify)
uo		tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Worl	k? Yes 2 □ No	LOQ. DESCRIBE NO	w injury occurred	
Division	or Attanding after death. Diractor: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	nome, farm, st	reet, factory, office				Rural Route Number,
Ö	s after de la Diract	Certification:	4 Homicide	building, etc. (Spec	ity)			City or Town	, State)	
	To the Hospital of within 24 hours at To the Funaral Completely filled in	edical (	(Check only 2 Medical Exemine	ian: To the best of my knr: On the basis of examin						
	o the ithin 2 o the omplei	Med	one) 29b. Signatule and title of certifier	and manner stated.		29c. License	e number	29	9d. Date signed (Mo	onth, Day, Year)
	F 3 F 8		1 Well	NO		D	52035	0	ecember	20 2004
•	10 81		30. Name and address of person who com	pleted cause of death (Ite		Print)	52035 Westmine	tr. Mi	n 2/15 2	}
	0		31. Date filed (Month, Day, Year)	32. Registrar's Sign						
	Sta Registr		DEC 2 0 2	32. Registrar's Sign	, J.	books				

		Í	For State Registrar	State of N	/larylan		artment of H			-	giene Reg. No.	004	42313
	Physici	an	Decedent's Name (First, Middle,				D			2. Date of De Month	ath Day	2004	3. Time of Death
	/Medio Examir		Sarah  4a. Facility Name (If not institution,	Augusta give street and numbe	r)		Ream 4b. City, Town, or	Location of	of Death	10		unty of Death	70.0
	Exami	ler.	11	ional Med	rial C	enter	Sala	sbur	,		16	Ulcome	ics
	Funeral				Age (In yrs.	last birthday, Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da			place (State or Foreign ntry)
	Director		218-34-8710 Usual Residence of Decedent		89	113.				09-21-	1915	Mary	yland
	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examinat must be notified at	_	10a. State 10b. County		10c. Cit	y, Town or L	ocation					1	10d. Inside City Limits 1 XYes 2 ☐ No
	the Mi	Director	MD Somer	set	Ma	rion S	tation 10f. Zip Code				10g Citizen	of What Cour	
	3e or	i Dir	27078 Ream Lan	e.			2183	8			us		,
	death	Funerai	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Spec	cify Yes or No		Race - Americ Black, White,	
36	i within 72 hours after death with the Marylan tiene. r then "naturel", or Items 23e or 28e-1 show Itte Medical Examinet must be notified at	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes 2 € If Yes, Give	No		1 ☐ Yes 2 🕱 No	Specify:		110411, 010.7		ecify:	
21215-0036	turel'	ed b	3 Widowed 4 □ Divorced  15. Decedent's	Year or Dates Education	5:	16a. Dece	dent's Usual Occupa	ation			16b. Kind o	Wn of Business/In	ite dustry
215	within 72 ene. then "nai	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	or 5+)	(Give	kind of work done of DO NOT use retired	tu <i>ring</i> mos )	t of workin	ng			
			5	none		Home	naker	40 14-4-	-d- M	(Since Adiabate	Own E		
Maryland	e d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, La	151)						(First, Middle,	, Maiden Sur	mame)	
ary j	d 2 should th and Men 7 is marke treumetic	T <sub>0</sub>	Peter Johnson 19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mail	ng Address (Street a	$ ext{Lilli}$ and Numbe			er, City or To	own, State, Zip	Code)
	and 2 pallth a n 27 is er treu		Gretna Willis/D	aughter		27078	Ream Lan	ie, Ma	arion	Stati	on, MD	21838	
altimore,	of He fiten r oth		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3	□Removal from Sta		Place of Disponentery, cre	osition (Name of matory or other place	θ)	Da	ate	20c. Locati	ion - City or To	own, State
tim	permit. Pages Department of I Importent; If it eny injury or o		'4 ☐ Donation 5 ☐ Other (Spe	icity)	- 1		Cemetery			-2004	Pocom	oke Ci	ty, Marylar
Bal	permit. Pag Department Importent; I eny injury o	1	21. Signature of Funer Provided	oensee,	h		2. Name and Addres inman Fun						
	_		73a. Part1. Enter the disease, or c	omplications that caus	MOO:	295 1. h. Do not en	1673 Some ter the mode of dying	rset g, such as	Ave.	, Princ respiratory a	cess At	nne, M	D 21853 Approximate Interval Between
	Physician	1	shock, or heart failure. List or Immediate Cause (Final disease or condition		_	yocas	Sint or	eys (	ure				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	lughce of):	10	-0-		. /	-0:	10.	
Н	Examine	-	Sequentially list conditions,	b. Acro	as a consen	Cerse	re Awers	sepla	1 m	y rorde	as en	au ca	48-72m
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	when	mele	Nie	Leart	des	in				urs
o,	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or a	as a conseq	juence of):			-				
8760	ate be hysiciá the bu	Ilcal		d.								-	
9 xo	eath certific attending pl	Physician/Medical	IF FEMALE:	23c. If yes, outcom	ne of predna	ancv					204	Data of dality	
Bo	attene attene	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 🗌 Feta	I death 3	☐Ectopic pregnancy ☐ Other (specify)				230.	Date of delive Month	ery Day Year
0	at the de by the tached	hysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	١								
s, P	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant condition	s contributing to death	but not res	ulting in the t	anderlying cause give	en in Part I					he cause of death?
ord	w requir been si should									10	Yes 2 N	o 3 Prot	oably 4 Dunknown
Records,	e taw has b je 2 si	Completed						-		24a. Was autop		4b. Were auto prior to co death?	opsy findings available impletion of cause of
Vital		e Co	25. Was case referred to medical				-	os Place	of Death	1 Yes	2 No	1 🗌 Yes	2 No
Z	Physicien: this certific ral director,	0 8	examiner?	Hospital:	atient 2	ER/Outpatie	nt 3 DOA Othe	ac.		ne 5 Resi		Other (Specif	5y)
n of	ding Ph h. After th funeral	on; T	27. Manner of Death	28a. Date of It		28b. Time of	of 28c. Injury Work	at k?	2	8d. Describe	how injury oc	curred	
sio	Attending r death. sctor; After by the funer	catio	2 Accident investige 3 Suicide 6 Could no	tion				Yes 2 🗌		106 1	O		10
Division	or Attendated after death Director;	Certification;	4 Homicide determin	ad 286. Place of	etc. (Specif	ome, farm, st	reet, factory, office		2	City or To		um <i>ber or Hura</i>	al Route Number,
	To the Hospitel or A within 24 hours after To the Funarel Direct completely filled in by	Medicai C		Physician: To the be kaminer: On the basis and manner	of examina								
	Fo the within Fo the comple	Me	29b. Signature and title of certifier				29c. License	number			29d. Date si	gned (Month,	Day, Year)
	- >- 0		Gara 20	Roof m. 1	٥,		Dog	0192	89		1	2/18/	04
			30. Name and ddress of person w	ho completed cause of	f death (Iter	n 23a) (Type	, Print)			( 1, 1			24
	- N		CLay or L Rado 31. Date filed (Month, Day, Year)	- m. o.	/ 3 / 5 trar's Signa	Sous	Print) Divis	ion s	F	) alis b	my M	0 2180	'1
	St Regist	ate rar	DFC 2	3 2004	guai s Signa	***************************************	South ,				)		

DHMH 17 Rev 1/2001

0118-48-810

Sarah Ream

			•	State of Maryland / Depart			•		42314
			State Registrar	Cei	rtificate of			Reg. No.	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Amanda	Ra	ndolph	2	. Date of Dea Month 12	13 2004	3. Time of Death A. 08:36 M
	Examin		4a. Fecility Name (If not institution, give st			r Location of Death		4c. County of Dea	
		Ц	Laurel Regiona  5. Social Security Number 6. Sex	T. Age (In yrs. last birthday)	Laurel  If Under 1 Year		. Date of Birt	Prince (	
	Funeral Director			M 2⊠F 19 Yrs.	Months Days	Hours Min.	1 1 3 1 Day	y8'gar) Mc	thplace (State or Foreign BUY) and
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	cto	MD ANNE A	rundel Laurel					1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	ountry?
	s 23e	gra	54 South Bruce		20724	dispania Origin? (Specif	fy Yes or No.	USA 14. Race - Amo	nican Indian
40	ter de ritem iner	Fune	11. Marital Status 1  1 X Never Married 2 Married 1	1 ☐ Yes 2 X No		lispanic Origin? (Speci an, Mexican, Puerto Ri	can, etc.)	Black, Whi	
036	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🕱 No	Specify:		Specify: b]	ack
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece completed) (Give	dent's Usual Occup	oation during most of working d)		16b. Kind of Business	/Industry
Maryland 21215-0036	withIn ine. ihan "	To Be Completed by Funeral Director	Elementary/Secondary (0-12)		DO NOT use retire tudent	d)		college	<b>:</b>
2	filed v Hygie thar t	ပ္ပ	17. Father's Name (First, Middle, Last)			18. Mother's Name (/	First, Middle,		
<u>a</u>	ld be ental kad o	o B	Felix Fagbemi			Prudenc	e Ran	dolph	
ary	shou and M e mar		19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mailie	ng Address (Street	and Number or Rural F	Route Numbe	er, City or Town, State,	Zip Code)
	and 2 salth a n 27 le		Prudence Randol				-	1, MD 207	
ore	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	20b. Place of Dispo cemetery, crei				20c. Location - City or	Town, State
Baltimore,	. Pag tment tant:		`4 □Donation 5 □ Other (Specify)	Ft. Line			1.4	Brentwood	, MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28a-f show any injury or othar traumatic event, the Medical Examinat must be notified at angree.		21. Signature of Funeral Apprice Libense		K Henr	ry Funera	l Cha	pel Inc.	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one			reet NE V			Approximate Interval Between
	Dhusisian '		Immediate Cause (Final						Interval Between Onset and Death 1 hr.
	Physician Medical		disease or condition resulting in death)	Cardiopulmonar  Due to (or as a consequence of):	y Arres	3 L			1 114.
в	Examiner		Sequentially list conditions b	Systemic Lupus	Erythe	ematosis			4 yrs.
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):					
	be executed ician and burial-transit	Examiner	that initiated events c.	Due to (or as a consequence of):					
760,	te be e ysician ie buris	calE	L a						
89	certificate Iding phy Ise as the		0.						
Box	th cert endin	M/ue	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnanc	v		23d. Date of de	•
Э. В	e deal	slcia	in the past 12 months?  1  Yes 2 No		Other (specify)	,		Month	Day Year
P.0.	w requires that the death certificate be executed been signed by the attending physician and should be delached for use as the burial-transit	Completed by Physician/Med	9 ☐ Unknown  Part II. Other significant conditions conf	the of the thorough the con-	nderlying cause on	ven in Part I	23e. Did to	obacco use contribute to	the cause of death?
ds,	signe d be c	d by	multiple CVA's,						robably 4 Unknown
Sor	w requ	letec	gastrostomy tube	e. anemia			24a. Was	an 24b. Were a	utopsy findings available
Re	e la has je 2	ошо	gaberobeom, case	,			autop perfo	rmed? prior to death?	completion of cause of
ta		Be C	25. Was case referred to medical			26. Place of Death (	1 □ Yes Check only o	7.	20140
Į V	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 🙀 No	ospital: 1  Inpatient 2  ER/Outpatier	nt 3 DOA Ott	ner: 4 Nursing Home	5 ☐ Resid	dence 6 □Other (Spe	cify)
0	nding Physician: ath. r: After this certific ie funeral director,		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time o	Wo	rk?	d. Describe h	now injury occurred	
sio	tendi Jeath. tor: A the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	CO. Place of lainer. Albama form at		Yes 2 □No	f Location /	Street and Number or R	uml Pouto Number
Division of Vital Records,	l or Al after d Dirac	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	20	City or Tox		mai nobie ivaliber,
	To the Hospital or Attend within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical C	29a. Certifier (Check only one) 1X Certifying Phys 2 Medical Examin	ician: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.	h occurred at the ti vestigation, in my o	me, date and place, an opinion, death occurred	d due to the at the time,	cause(s) and manner a date and place, and du	s stated. to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	211	29c. Licens			29d. Date signed (Mon	h. Day, Year)
			> Kita K	20 (a mo	D004	47707		12/13/04	
01	(3)		30. Name and address of person who con			urol Mr	2070	7	
F-(			Rita Pabla MD	13621 Baltimore	AVE La	aurel, MD	2070	1	

State Registrar

31. Date filed (Month, Day, Year)
DEC 2 3 2004

Registrar's Signature

1			1 - State AMENDED 1, 12/21/04	Maryland /	Department of	f Health and M	ental Hy	giene 004	42315
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) John B. THOMAS ROUTE THOMAS ROUTE THOMAS ROUTE THOMAS	E IV	200	<del>- IV</del>	2. Date of De Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number	noita	4b. Ofty, Town	for Location of Death		4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 7. / 217-44-1945 XXM 2 F	Age (In yrs. last)	birthday) If Under 1 Ye Months Da	ar If Under 24 Hrs.	8. Date of Birt (Month, Da Sept 1	9. Birl 9, 1946 Mary	thplace (State or Foreign ountry) yland
~	death with the Maryland ms 23a or 28a-f show critical be notified at	٦٢	10a. State 10b. County Maryland Dorchester		own or Location  mbridge				10d. Inside City Limits 1 ☐ Yes 3(X)No
Z	or 28a-f	irect	10e. Street and Number		10f. Zip Cod	e		10g. Citizen of What Co	
3	s 23a c	erai D	208 Johnson Street  11 Marital Status 12. Was Deceder	at Ever in II C	1	1613	seife. Van as bla	US 14. Race - Ame	occan Indian
036	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural; or Items 23a or 28a-1 show event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced  12. Was Deceder  1 Married  14. Was Deceder  1 Yes 3 Wildowed  1 Ves 3 Wildowed  1 Ves 4 Wildowed	s? ₹No	If Yes, specify C	of Hispanic Origin? (Spe Cuban, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Black, Whit	White
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	pieted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4o	16 or 5+)	6a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation ine during most of worki tired)	ng	16b. Kind of Business	/Industry
21	led with		12  17. Father's Name (First, Middle, Last)		Owner/Ope			Fire Equipa	ment Supply
land	routd be fi I Mental H Parked of:	To Be	John Thomas Roe II	Т			nces St	·	
lary	and M and M is mar	-	19a. Informant's Name/Relationship (Type, Print)		9b. Mailing Address (Str				Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Brenda Roe Wife  20a. Method of Disposition	20b. Place	P.O. Box 6. of Disposition (Name of Disposition or other)	55 Cambridg	e, Mary	land 21613 20c. Location - City or	Town, State
Mor	eg = 5		1 Burial 2 Cremation 3 Removal from Star 4 Donation 5 Other (Specify)		stery, crematory or other		/04	Salisbury	
Baltimore,	permit Pa Departmer Importent any in ury		21. Signature of Funeral Service Licensee		22. Name and Ad	The state of the s	-	1,	-
	Physician /Medical Examiner	Examiner	23a. Part1/Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a cause (Disease or injury that initiated events resulting in death) Last	as a consequence	op not enter the mode of lelimone of some Signature Sign	a toke lation	ambridg	e, Maryland	Approximate Interval Bayween Onset and Death S
P.O. Box 68760	death certificate e attending phys	Physician/Medical E	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2 Fetal dea at time of death	ath 3 Ectopic pregna 5 Other (specify	)		23d. Date of de Month	Day Year
	uires th signed Id be d	þ	Part II. Other significant conditions contributing to death	Dut not resulting	g in the underlying cause	given in Part I.		obacco use contribute to ′es 2□No 3□Pr	robably 4 Unknown
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed					24a. Was autop perfo 1 🗆 Yes	rmed? prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			26. Place of Death		_	
ō	After une	ation: To	27. Manner of Death 28a. Date of In		b. Time of lnjury 28c. I	4   Nursing Hor		dence 6 □Other (Spe now injury occurred	cify)
Division	el or Attend after death I Director: d in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of building,	Injury - At home, etc. (Specify)	, farm, street, factory, offi	ice	28f. Location (5 City or Tox	Street and Number or Ro vn, State)	ural Route Number,
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by ti	ledical C	29a. Certifier (Check only one)  Certifying Physician: To the best and manner	of examination	dge, death occurred at the and/or investigation, in n	e time, date and place, a	and due to the ed at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the To the comp	ž	29b. Signature 4 Pe O certifier		29c. Lio	06028	_	29d. Date signed (Mont	16 2004
			30. Name and address of person who completed cause of the cause of the cause of the completed cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of	death (Item 23)	a) (Type, Print)	time M	D 21	287	
	Sta Regist		30. Name and address of person who completed cause of both 500 kg. 31. Date filed (Month, Par Year) 1 200 432. Reg	Arar's Signature	& Sperke	J. 1 1	ا س	V U I	

			For State Registrar	State of Ma	aryland / Do	epartment of F Certificate of	lealth and I Death	Mental Hy	giene 2 (	104	42316
			Decedent's Name (First, Midd	le, Last)				2. Date of De	aath Day	Yeer	3. Time of Death
	Physicia /Medic		Garfield Wilmo	ore Rodgers				Decemb	_ ′	2004	7:45 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution	on, give street and number)		4b. City, Town, o	or Location of Death	n	4c. County		
			Carroll Hosp		a dia cana bank binta	Westmins		R Date of Di	Carro		lace (State or Foreign
1	Funeral		5. Social Security Number		e (In yrs. last birth 1 Yı	Months Days	Hours Min.	(Month, Da	ay, Year)	Coun	inore, MD
	Director		217-40-8388 Usuel Residence of Decedent					Cct. 1	7, 1943	Dalt.	more, MD
	aryland show		10a. State 10b. Count		10c. City, Town					10	0d. Inside City Limits
$\stackrel{\frown}{\sim}$	a-f si	ctor	MD Can	roll	Finksbu	rg					1 ☐ Yes 2 ☑ No
7	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
7	death with the Maryland me 23a or 28a-f show		1702 Fawn Way	1		21048	E		U.S.A	ce - Americ	on Indian
1	er de Itemé	Funeral	11. Marital Status  1 □ Never Married 2 ★ Ma	12. Was Decedent Armed Forces?		<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	an, Mexican, Puerl	to Rican, etc.)	Bla	ick, White,	
36	ours after death with the Maryla el', or Heme 23a or 28e4 shov Esst it et must be colified at	by F	3 Widowed 4 Divorce	If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specif	v: Whit	te
S GARFIEL		ted		nt's Education est grade completed)	16a. [	Decedent's Usual Docup	pation	rkina	16b. Kind of B	iusiness/Inc	dustry
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or		Give kind of work done life. DO NOT use retire ESMAN	d)	9			western
W 2	be filed within 72 h ital Hygiene. id other then "netu event, tre Medical	Con		4	Dai		10 Mather's Nor	no /Einst Middle	Branch  , Maiden Sumai		Ls
2	be filed ntal Hygi od other	Be	17. Father's Name (First, Middle Bernard J. Roo					t L. Ec		110)	
2 Z	should ind Men marke umaric	70	19a. Informant's Name/Relation	-	19b. I	Mailing Address (Street				, State, Zip	Code)
	and 2 s ealth an n 27 is		Donna J. Rodge		17	02 Fawn Way	, Finksb	ourg, MD	21048		
Rolfer Baltimore, Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other than any injury or other traumatic event, Ital Mg. Once.		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other pla	ce)	Date	20c. Location	- City or To	wn, State
A 0 m	Page nent o int: if		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (			1 Cremation		21/04	Hampstea	ad, M	)
==	permit. Departrimporte any inju		21. Signature of Funeral Service	Licensee							Chapel,P.A.
_		TE I	19 arh/	Vertuell	10	412 Washii				MD 2.	
			23a. Part 1 Enter the disease, shock, or heart failure. Lis	or complications that caused tonly one cause on each li	d the Beath. Do no	ot enter the mede of dyi	ng, such as cardiae	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Ker	al of	allur	e				1 week
	/Medical Examiner		1850thing in docum	Due to (or as	a consequence/of						
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (at as	a consequence of	):					
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>	0						
c	an an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of	):					
8760	ate be hysicii he bu	dical		d							
9	entifica ling pl	Med	IF FEMALE:	000 15 1100 01100 01100							
Box	leath certific attending	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 □Ectopic pregnance 5 □ Other (specify)	у			ate of delive onth	Day Year
C	that the death certificated by the attending posterior detached for use as	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	t time of death	o a carer (specify)					
Division of Vital Records P.O.	or Attending Physician: The law requires that the death certificate be infer death.  Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the but	by Physician/Me	Part II. Other significant condi	tions contributing to death t	out not resulting in	the underlying cause gi	ven in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of death?
70	v requires been sign should be	d be			· · · · · · · · · · · · · · · · · · ·			1 🗆	Yes 2□No	3 Prob	ably 4 Nunknown
Ç	law requ	Completed						24a. Wa	s an 24b.	Were auto	psy findings available
ä	The lav	mo						perf	ormed? 2 No	death?	2 No
<u></u>	ician: Th	Be	25. Was case referred to medic examiner?					ath (Check only	one)		
2	Physic this co	2	1 Yes 2 No	Hospital: 1 Inpati		Datient 3L DOA			sidence 6 Ot		()
2	ding P h. After I	lon	27. Manner of Death 1 Natural 5 □ Pend		ay Year) 28b. Ti	jury Wo	ry at ork? ]Yes 2 ☐ No	28d. Describe	how injury occu	rred	
	ottendii death. ctor: A y the fu	icat	3 Suicide 6 □Coul		jury - At home, fan	m, street, factory, office		28f. Location	(Street and Num	ber or Rura	l Route Number,
2	of or Attend after death Director: /	Certification;	4 Homicide deter	mined building, e	tc. (Specify)			City or To	own, State)		
	spite hours inerel y filled			ing Physician: To the best							
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	one)	al Examiner: On the basis of and manner si	ated.			urred at the time			
	Vith To t	Σ	29b. Signature and title of certif	ler/		29c. Licen	se number		29d. Date sign	∌d (Month, i	Day Year)
	WJL		Kenno	routle,	D.O.	400	0558	45	12/0	20/	2004
	10		30. Name and address of person	n who completed cause of	death (Item 23a) (1	Page Frint)	Dd 11	2-7.	11110	TEP	MI
		ate	31. Date filed (Month, Day, Yea	17) 32. Regist	rar's Signature	100LE F	1	ES//	7/103/	EN	21157
	Regist		DEC	. 24	alua B.	Courses					4115/

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No LUU4 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 23, 2004 **Physician** BAINARD CORNELIUS STEWART 1900 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK FREDERICK CITIZENS NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year APRIL 2, 1 Birthplace (State or Foreign Country)
 SC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 251-05-0286 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 Yes No HAGERSTOWN Director MARYLAND WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 10116 SHARPSBURG PIKE 12. Was Decedent Ever in U.S. Armed Forces? 1942— 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CHIEF ENGINEER RADIOLOGY CO. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be If itam 27 is marked SHELLEY JAMES STEWART EĽIZABETH LOUGHRIDGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARAH SHULTZ, DAUGHTER 2113 REED ROAD, KNOXVILLE, MARYLAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 MRemoval from State permit. Page Department of Important: If any injury or once. 12/29/2004 KANNAPOLIS, NC CAROLINA MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME Kelly A. Zimmerman BOONSBORO, MARYLAND 23a. Part 1. Enter the diseast or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or her trailure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** W /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, placease or a jury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) detached ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy 1 TYes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide hours after To the Hospital or within 24 hours at To the Funeral D 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	_ FUI	partment of Health and Me	ntal Hygiene	2001 10010						
	Dharaini		Decedent's Name (First, Middle, Last)	2	. Date of Death Month Da	3. Time of Death						
	Physicia /Medic		Edna H. Sesso		Month Da December 2							
	Examin	er	4a. Fecility Name (If not institution, give street and number) Villa Rosa Nursing Home	4b. City, Town, or Location of Death		c. County of Death Trince Georges						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Mitchellville y) If Under 1 Year   If Under 24 Hrs.   8	Date of Birth	O Bidholago /State or Forming						
	Funeral Director		578-40-0066 1□M 2 <b>©</b> F 91 Yrs.	Months Days Hours Min.	(Month, Day, Year) an. 30, 1	913 Wash. DC						
	pu .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits						
	Aaryla f sho	ō		llville		1 ☐ Yes 2 ☒ No						
	the N	Director	Md. Prince Georges Mitche	10f. Zip Code	10g. Ci	tizen of What Country?						
	h with	a D	3800 Lottsford Vista Road	20721	US	SA						
	ems ?	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Rid	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.						
36	or it	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No Specify:		Specify: White						
Ö	hour fural	Completed by	3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16b. K	Kind of Business/Industry						
7	nin 72 in "na	plet	(Specify only highest grade completed) (Gi	ve kind of work done during most of working . DO NOT use retired)								
21,	giene giene er the	Com	6 Re	eceptionist	Opt	tician						
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (F								
ya	a Men narke	٥	William Dent Cheseldine	iling Address (Street and Number or Rural F	y Madeline							
Mai	d 2 st th and th and traun			.0 Spring Green Ave.								
ē,	s 1 and 2. of Health ar Item 27 io		20a Method of Disposition 20b. Place of Dis	position (Name of Date rematory or other place)		ocation - City or Town, State						
E O	Page:		1 X Burial 2   Cremation 3   Hemoval from State	111 Cemetery 12-23-0	O4 Suit	tland, Md.						
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic event, If a Medical Exertified to incitied at once.		21. Signature of Funeral S. Lidensee 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715									
			23a. Part1. Enter the disease, or complications that caused the death. Do not e			Approximate						
	Pnysician :		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Chronic obstruct	rive pulmonary diseas	se	Interval Between Onset and Death Vears						
	/Medical		resulting in death)  a									
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	ed sit	Examine	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury									
	al-trar	Exan	that initiated events cresulting in death) Last c.  Due to (or as a consequence of):									
8760,	death certificate be executed e attending physician and ind for use as the burial-transit		d									
9	rtifical ng phy as th	Medi	IF FEMALE:									
Вох	leath certifica attending ph	lan/I	23b. Was decedent pregnant in the past 12 months?	B Ectopic pregnancy		23d. Date of delivery  Month Day Year						
P.O. I	res that the de signed by the a l be detached f	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 ☐ Other (specify)								
	that the by detail		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?						
rds	w requires been sign should be	ed by	Alzheimers disease, osteoa	thritis	1 ☐ Yes 2	□ No 3 □ Probably 4 📆 Unknown						
of Vital Records,	m vi oi	Completed	chronic anemia		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Ä	The ate ha	Com			performed? 1 ☐ Yes 2 🖾 No	death?						
/ita	Physician: Th this certificate al director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (0	Check only one)							
of	Phys this al di	۲: T	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time			6 □Other (Specify)						
	ding h. After funer	tlon		28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work?								
Division	f or Attending after death. Director: Afte I in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office 28	f. Location (Street ar City or Town, State	nd Number or Rural Route Number,						
Ö	ital or rs afte al Dir	Cert	building, etc. (Specify)	,	Ony or rown, oldin							
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, de control on the basis of examination and/or and manner stated.									
	To the I	M	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)						
			I Ville M.D.	D22549	Dece	ember 22, 2004						
2	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type G.M. Din, MD, 6510 Kenilworth Ave.	•	37							
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 3 2004  Registrar's Signature	_								
		-										

		1	For State Registrar	State of Maryland / [	Departme Certifica				giene Reg. No	ΩL	12319
ı	Physicia /Medic	an	Decedent's Name (First, Middle, Las GEORGE	villiam	SWA	ISON		2. Date of Dea December	er 78, 2	0°4	3. Time of Death 6:25P. <sub>M</sub>
•	Examin	0.5	4a. Facility Name (If not institution, give Ellicott City Heal	street and number) th and Rehab Ctr	4b. City		Location of Death t City		4c. County Howa		
	Funeral Director		5. Social Security Number 6. Security Number 1550-22-1062 11	3	thday) If Und Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March29		Cour	elace (State or Foreign http) ifornia
	72 hours after death with the Maryland natural; or liems 23a or 28a-f show acal Examinat must be notified at	Director	10a. State 10b. County Prince (	George's Laure	1	p Code			10g. Citizen of \		0d. Inside City Limits 1 ☐ Yes 2X No
	th with 23a or		12810 Silverbirch	n Lane		2070	8		United	State	es
36	hours after deat hturel', or Items :	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □X*es 2 □ No If Yes, Give Year or Dates:1942_1946	13. Was Dec If Yes, sp		spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	k, White,	ean Indian, etc. White
9500-612	in 72 hou n "nature Modical E	Completed	15. Decedent's Ed (Specify only highest grad	ucation 16a	Decedent's Us (Give kind of w life. DO NOT	ork done d	luring most of work	ing	16b. Kind of B	usiness/Ind	dustry
212	filed within hygiene.  Hygiene.  other then "sent, It e Mac	Com	Elementary/Secondary (0-12)	College (1-401 5+)	ab Tech	nolog			Health		
Maryland	ld be ental ked c	To Be	17. Father's Name (First, Middle, Last) Axel H. Swanson				18. Mother's Name Karin P.			16)	
Man	d 2 sho		19a. Informant's Name/Relationship (7 Betty J. Swanson		_		ind Number or Run rch Lane				-
	os 1 and of Health fitem 27		20a. Method of Disposition	20b. Place o	of Disposition (Nature) or	ime of	! !	Date	20c. Location -		
altimore,	permit. Pages 1 and 2 shou Department of Health and M mportent: If item 27 Is mar any injury operher traumati anse.		1 XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Maryla	nd Vete	rans	Cemetery				
Bai	permit Depart Import any in		21. Signature of Funeral Service Licen	See Constitution of the Co	Dona I	nd Addres	s of Facility Borgwardt Mill Roa	Funera	1 Home,	P.A.	0705
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olivations that caused the death. Do not cause on each line.  a	not enter the mo	de of dying	g, such as cardiac	or respiratory ar	rest,	Silvania er	Approximate Interval Between Onset and Death
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a consequence c	· <u>-</u>						
8760	icate be physicials the buri	dical		d							
O. Box 6	ne death certif the attending hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 ⊟Ectopic 5 ⊟ Other (					te of delive	ery Day Year
rds, P.	quires that the signed by aid be detact	by	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying	cause give	en in Part I.	23e. Did to	1		he cause of death?
I Records,		Completed						24a. Was autop perfor 1 \( \text{Yes} \)	rmed?	Were auto prior to co death? I  Yes	psy findings available mpletion of cause of 227No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deat				
Division of Vital	Attending Physician: r death. sctor: After this certifics by the funeral director, I	ation; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	utpatient 3 () () Time of Injury M	28c. Injury Work	4 Thursing Ho	ome 5 Resid	ience 6 ∐Oth now injury occur		()
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, facto	ry, office		28f. Location (5 City or Tow		er or Rura	al Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exem	ysicien: To the best of my knowledg niner: On the basis of examination and and manner stated.	e, death occurre nd/or investigation	d at the tim	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and ma date and place,	anner as s and due to	lated. the cause(s)
}	V V Vithi	M	29b. Signature and title of continer	Ma		C License	7746		29d. Date signe Decembe	d (Month, r 20	Day, Year) , 2004
	(3)		30. Name and address of person who Yelena Lipnik, M			Lane	Catonsvi]	lle, Mar	yland 2	1228	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) <b>DEC</b> 21 20	32. Registrar's Signature	5 de	rocks					

			i icase	State of Man	vland / Der				lental Hv	aiene	2091210		
		•	For State Registrar	State of Man			te of Dea			Rea. No	71111	4:	2320
			Decedent's Name (First, Middle, L.	.ast)					2. Date of Dea Month	-			e of Death
	Physici /Medic		KENNETH	E. Sh	/ITH				DEC 1				:30A <sup>M</sup>
	Examin		4e. Facility Name (If not institution, g	ive street and number)	- TT	4b. City	yattsvi	tion of Death		4c D	County of De	ath Ceor	re 's
			Gladys Spelln	an Nursing	Home			nder 24 Hrs.	8. Date of Birt				
	Funeral				In yrs. last birthda 57 Yrs.	Months			Aug 2	y, Yeer)	37 Ma	ountry) aryla	nte or Foreign nd
	Director	1	216-30-4812 Usual Residence of Decedent							,			
	nyland how		10a. State 10b. County	1	Oc. City, Town or								e City Limits
	sa-f s	cto	MD Prince	e Georges	Land	over							Yes 2 □ No
	be filed within 72 hours after death with the Maryland the Hygiene.  and Hygiene.  ad other than "natural", or Items 23s or 28s-f show other than "natural", or Items 23s or 28s-f show event, the Medical Examination must be indiffed at	Director	10e. Street and Number			10f. Z	ip Code 20785			-	tizen of What (		
		by Funerai	7112 E. Forest	Road	Road						14. Race - An		٦,
	fter de	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛂 No	1 ☐ Yes 2 🔼 No			Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F			Black, White, etc.		
936	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	If Yes, Give 1 ☐ Yes 2 No Specity: Year or Dates:						Specify: B.	lack	
5-0	72 ho	Completed	15. Decedent's (Specify only highest of		(Gir	ve kind of w	ual Occupation	most of work	ing		ind of Busines	s/industry	
121	within ne. han	Idu	Elementary/Secondary (0-12)	College (1-4or 5+)			sor II				-		
D	filed Hygi ther int, I	ပိ	12th 17. Father's Name (First, Middle, La	st)	Dar			Mother's Name	e (First, Middle,		ublic Sumame)	Work	S
an	should be ind Mental I	To Be	Wayman Sm	ith				Daisv	Smith	l			
ary	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked, any injury of other traumatic avants.	-	19a. fnformant's Name/Relationship		19b. Ma	iling Addre	ss (Street and Nu				or Town, State	Zip Code)	
Ž,	and 2 alith a n 27 ts		Claudia Smith	- Wife			Fores						
ore	of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3	☐Removal from State		rematory or	other place)		Date		ocation - City o		9
Baltimore, Maryland 21215-0036	ment tant:		`4 □Donation 5 □ Other (Spe	city)			m Cem.						
Bali	Sermit Separ mpor iny in		21. Signature of Funeral Service Lic	emsee	2011		and Address of F						
	403402		23a Part 1 Enter the disease of co	mulications that caused th	e death. Do not e		N. Was				KATTT	Approx	imate
			shock, or heart failure. List on fmmediate Cause (Final		one cause on each line.  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death								
	Physician /Medical		disease or condition resulting in death)	a	a. ACUTE MYOCARDIAL INFARCTION  Due to (or as a consequence of):								
	Examiner			ARTERIOSCLEROTIC HEART DISEASE									
Sel.	4 · · · · ·	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a consequence of):								
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								-	
760,	ate be executed hysician and he burial-transit	cal Ex	resulting in county cast	Due to (or as a c	Due to (or as a consequence of):								
687	leath certificate t attending physic I for use as the b	edica	8	d									
×	The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome of pregnancy						23d. Date of c	elivery	
Box	death a atter d for i	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								Month Day Year	
P.0	by the tached	Physician/M	9 🗆 Unknown	9□ Unknown									
	es tha igned	by F		•	_	,				23e. Did tobacco use contribute to the cause of deat  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unk.			
Vital Records,	w requir been si should		CEREBROVASCU	LAR INFARC	TIONS MI	2T T T T	TIC			105 2	I NO J	INO 3 Probably 4 Nonkriowii	
ec	has b	Completed	INSULIN DEPENDANT DIABETES MELLITUS  24a. Was an autopsy performed?							psy	24b. Were autopsy findings available prior to completion of cause of death?		
al F	(0								1 Yes	<b>≥</b> C No			
V.	Physici r this cer ral direc	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 [2]No	26. Place of Death (Check only one)  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: W Nursing Home 5   Residence 6   Other (Specify)									
Division of		$\vdash$	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at					28d. Describe how injury occurred				
	Attending I ir death. ector: After by the funer	Certification:	1X Natural 5 ☐ Pending 2 ☐ Accident investiga		(eer) Injur	M	1 Tes	2 🗆 No					
Vis	after des Directo	tifle	3 Suicide 6 Could no 4 Homicide determin	ad 200. Place of Injury	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			Number,
	spital or nours after neral Dir		~~~					ļ.					
	Hospital 24 hours a Funeral stely (illed	Medical	29a. Certifier f Certifying (Check only 2 Medical Ex	Physician: To the best of terminer: On the basis of each manner state	xamination and/or	ath occurre investigati	ed at the time, da on, in my opinion	ite and place, i, death occur	and due to the red at the time,	cause(s date an	<ul> <li>and manner</li> <li>d place, and d</li> </ul>	as stated. ue to the cau	se(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of contifier 29c. License number						29d. Date signed (Month, Dey, Ye			nth, Dey, Ye	ar)
1	5 5		1000	1/6 170	2	D0026024 D					December 18, 2004		
(=	5) 5		30. Name and address of person w	no completed cause of dea	ith (Item 23a) (Typ	oe, Print)	10020	,044		2/01			
			Lester Miles				ad, Lar	ndover	, MD	207	85		
		ate	31. Date filed (Month, Day, Year)  NFC 2 1 2	32. Registrar'		1	actas						
	Regist	rar	HEG ZIZ	UU4 /W	1	100	- 104 - 00						

			For	State of M		nd / Dep	artment of H rtificate of L	lealth and	•	giene	noie.	10001	
			1 - State Registrar	(ant)			runcate or t	Jeani	2. Date of De	Reg. No U	04	4/3/	
	Physicia	an	Decedent's Name (First, Middle						Month	Day	Year	3. Time of Death	
	/Medic	al		SCHECK			th City Town or	Location of Dog	DECEMB			3:52 P M	
	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or	Location of Dea	ın		ty of Death		
-			MONTGOMERY GENER  5. Social Security Number			last birthday	OLNEY  If Under 1 Year	If Under 24 Hrs	8. Date of Bi	MONTG		lace (State or Foreign	
	Funeral Director		567-28-0528	1 <b>∑</b> M 2□F		93 Yrs.	Months Days	Hours Min	.   (Month, D	ay, Year) • 1911	AUSTI	place (State or Foreign ntry) D.Τ.Λ	
			Usual Residence of Decedent							, 1)11			
	nylan show	_	10a. State 10b. County		10c. Cit	ty, Town or Li	ocation				11	Od. Inside City Limits	
	Ba-f e	cto	MARYLAND MONTGON	IERY	SAN	DY SPR	ING					1 X Yes 2 □ No	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural; or Items 23a or 28a-f show event, I'm Marical Examinar must be multified at	Director	10e. Street and Number				10f. Zip Code			10g. Cîtizen o	What Coun	itry?	
	ath w		1641 HICKORY KNO				20860				.S.A.		
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (: n, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o-   14. Ra	ace - Americ ack, White,		
2	rs att	by F	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No		1 ☐ Yes 2X No	Specify:		Spec	ify: WE	HITE	
3	hour	ed k	15. Decedent			16a, Dece	dent's Usual Occupa	ation		16b. Kind of			
2	in 72	piet	(Specify only highes	t grade completed)	5.1	(Give	kind of work done of DO NOT use retired	during most of wo	orking	100.14.110.01	54511195341110	240119	
7	iene r the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	ORTHO	PEDIC SUR	GEON		MEDICA	L		
2	filled I Hyg othe	Be C	17. Father's Name (First, Middle, I	ast)				18. Mother's Na	me (First, Middle	, Maiden Suma	ime)		
0	uld ba lenta rkad tlc ev	To B	LEOPOLD	SCHECK				CECELIA		(UNKN	OWN)		
7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Items 23s or 28s-f show any injury or other treumetic event, the Mudical Expirit retinal be notified at once.	-	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street	and Number or F	ural Route Numb			Code)	
Ē	and 2 ealth a m 27 ls		ANITA G. GOLDHAR	R/DAUGHTER		724 M	ILSHIRE C	T., SIL	ER SPRI	NG, MD	20905		
Ď	item item		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other plac		Date	20c. Location		wn, State	
2	Pages nent of h int: If ite		1 🕅 Burial 2 □ Cremation `4 □ Donation 5 □ Other (Sp				M. GARDEN		21/2004	OLNEY.	MARYLA	AND	
	permit. Pages 1 and Department of Health Important: If item 27 any njury or other troops.		21. Signature of Funeral Service L	icensee			2. Name and Addres NZANSKY – G						
Ď	P. P. P. P. P. P. P. P. P. P. P. P. P. P		Sonald C.	Stottle	nu	<u>د</u> آآ	70 ROCKVI	LLE PIKI	E, KUCKV	ILLE, M	D 2085	52	
			23a. Part1. Enter the disease, or shock, or heart failure. List									Approximate Interval 8etween	
	Physician	ļ 1)	Immediate Cause (Final	MULTISYS							2/	Onset and Death 4 HOURS	
	/Medical		disease or condition resulting in death)	Due to (or as			PATLONE					+ HOOKB	
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  LINTRAABDOMTNAL MASS  Due to (or as a consequence of):  c.								24	HOURS	
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	ate be executed sysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events	c									
Ś	e exe ian al ırial-1		resulting in death) Last	Due to (or as	a conseq	juence of):					II.		
	ate be nysici	icai		d									
ž	The law requires that the death certificate ate has been signed by the attending physipage 2 should be detached for use as the lines.	Physician/Med	IF FEMALE:			7) T							
	ith ce tendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth			⊒Ectopic pregnancy				ate of delive	ery Day Year	
	e dea he at	sici	1 Yes 2 No	4☐Pregnant a 9☐Unknown	t time of c	leath 5	Other (specify)		-	10	OHII	Day Teat	
	d by etach	Phy				lata — to alon .		— — — — — — — — — — — — — — — — — — —	22a Did	tahaasa waa sa	navibusa an ala	and an analysis	
Ď.	res th	by	Part II. Other significant condition	ns contributing to death t	out not res	suiting in the t	inderlying cause give	en in Parti.		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown			
5	v requir been si should	ompieted							• •	162 ZAJNO	3 1 100	ably 4 Donkhown	
ט	law lasb	npie			-				24a. Was	psv	prior to con	psy findings available mpletion of cause of	
=	Tha ate h	Con							1 ☐ Yes	ormed? 2 <b>X</b> No	death? 1 🔲 Yes	2□ No	
	ding Physicien: Tha law n. Atter this certiticate has b funeral director, page 2 s	Be	25. Was case referred to medical examiner?	No. 221					ath (Check only	one)			
5	Physi this c al dire	70	1 ☐ Yes 2 📉 No				nt 3 DOA	4   Nursing	Home 5 ☐ Res			0	
	ding P. Atter I	ion:	1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work?						28d. Describe	e how injury occurred			
2	tend death tor: / the f	cat	2 Accident investig	ot be				Yes 2 □ No	00/ 1				
_	or At tter o Dirac in by	Certification;	4 Homicide determi		jury - At h tc. <i>(Specil</i>	ome, farm, st fy)	reet, factory, office			wn, State)	iber or Hura	l Route Number,	
1	urs a		On Cartina M Cartinia	The later of the later					1				
	Hosp 24 ho Fune Fune tely f	edicai	29a. Certifier 1 ★ Certifyin (Check only 2 ★ Medical II	Physician: To the best examiner: On the basis of	of examina	owledge, deal ition and/or in	h occurred at the tim ivestigation, in my of	te, date and plac pinion, death occ	e, and due to the urred at the time,	date and place	nanner as st , and due to	ated. the cause(s)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific, completely filled in by the funeral director, t	Med	29b. Signature and title of certifier	and manner st	aleu.		29c. License	number		29d. Date sign	ed (Month. I	Day, Year)	
	F ₹ ₹ 8	_	1 LAL							•			
	10		The state of the s		200	- 000 7	D0035	045		DECEMB	ER 19,	, 2004	
	(			who completed cause of				20/- 013	TEV MAD	O CINATO	ດວາ		
	Sta	to	PHILIP G. HENJUN 31. Date filed (Month, Day, Year)	1, M.D., 341 32. Beoist	rar's Signa	ANDWOO ature 🔏	D COURT #	∠04, OLI	VLI, MAK	ILAND Z	0032		
	Sta Registr		nec 21	2004 Acres	التصمد	B	sporks						
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** SCHECHTER December 18. 2004 10:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr. | 8 | 1921 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F 83 065-12-6113 Yrs. Director New York Usual Residence of Decedent with tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Rockville Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20852 1801 E. Jefferson Street #422 United States or Itams 23a death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>Δ</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. parmit. Pages 1 and 2 should ba filad within 72 hours after c Department of Health and Mental Hygiene. Important: If trem 27 is marked other than "natural; or itan any injury of other traumatic event, the Medical Examinations." 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pincus Lindauer Celia Schmerzler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R657 Wawona St., San Francisco, CA 94116 19a. Informant's Name/Relationship (Type, Print) 3657 Joel Schechter, Son Wawona St., San Francisco, CA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Lebanon Cemetery | 12/20/04 Adelphi, MD 22. Name and Address of Facility 21. Signature of Funeral Servi Torchinsky Hebrew Funeral Home 23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final Priysician CEREBROUMSCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine cate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2/1 No 3 Probably 4 Unknown 1 Yes Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 📈 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Jeath 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9/04 D-27660 nnuai person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of MID 11119 ROCKVILLE, ALPANA GIUSWATHII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21 2004 DEC Registrar

3215

SCHECHTER

		•	1 - For State Registrar	State of Marylan	•	rtment of He tificate of D			giene 004	42323		
表	Physici	_	1 Decedent's Name (First Middle Last)			MINK		2. Date of Death Month Day Year DECCHBER 19 2004 7:47 PM				
	/Medic Examin	- 40	4a. Fecility Name (If not institution, give street and number) Howard County General Hospital			4b. City, Town, or Location of Death Columbia			4c. County of Dea			
1	Funeral Director		5. Social Security Number 6. Sex 215 28 5796 1四	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 21	, Year) C	rthplace (State or Foreign ountry) ryland		
	death with the Maryland ms 23a or 28a-f show (must be notified at	o.	Usual Residence of Decedent  10a. State 10b. County		ty, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2€ No		
	th the M or 28a-f s notifi	Director	MD Howard  10e. Street and Number		Ellicot	10f. Zip Code			l0g. Citizen of What C	ountry?		
0036	ath wi		3713 Tustin Road			21042			United Sta			
	after or ite	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 XNo If Yes, Give Year or Dates:</li> </ol>		Vas Decedent of His Yes, specify Cuban ☐ Yes 2 1 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.		
	be filed within 72 hours tal Hygiene. d other than "natural", event, the Medical Exa	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation completed) College (1-4or 5+)	(Give	ent's Usual Occupat kind of work done du DO NOT use retired)	ion Iring most of work		16b. Kind of Business			
2	e filed will Hygien other th		12 17. Father's Name (First, Middle, Last)		Pressm		18. Mother's Nam		Alco Gravu Maiden Sumame)	re		
and		To Be	Leroy Hume Smink			Florence						
ary	2 should be and Menta is marked eumatic ev	-	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailin	g Address (Street ar	nd Number or Run	al Route Numbe	r, City or Town, State.	Zip Code)		
_	es 1 and of Health f item 27 r other tr		Eleanor H. Smink/ 1 20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. I	Place of Dispos cemetery, cren	Tustin Ro sition (Name of natory or other place	)	Date	oc. Location - City or	Town, State		
Baltimore,	permit. Pag Department Important; I any injury o		*4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	the state of the s		. Name and Address	of Facility Har	ry H. W	Catonsvill itzke's Far licott City	mily F.H.Inc.		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the dea	th. Do not ente	er the mode of dying,	, such as cardiac	or respiratory arr	est,	Approximate Interval Between		
	Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence):									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
9	rtificate ng phys	Medicai	IF FEMALE:									
O. Box	ne death certific the attending p thed for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year			
۵.	luires that the de n signed by the a lid be detached i		Part II. Dther significant conditions con							tobacco use contribute to the cause of death?		
Records,		Completed				24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2						
Viital	ysicien: This certificate director, pag	Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 월		26. Place of Death (Check only one)						
Division of \	di is	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	2 PER/Outpatient 3 DOA Cither: 4 Nursing Home 5 Res  28b. Time of Injury Work? M 1 Yes 2 No				idence 6 Other (Specify) how injury occurred				
	To the Hospitel or Attending Phwithin 24 hours after death. To tha Funerel Director: After th completely filled in by the funeral	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fan building, etc. (Specify)			street, factory, office 28f. Location			(Street and Number or Rural Route Number, own, State)			
	To the Hospitel within 24 hours a To the Funerel I completely filled											
	To the withfin To the comple	Me	29b. Signature and title of certifier			29c, License	number	2	29d. Date signed (Mon	th, Day, Year)		
			30. Name and address of person who co	moleted cause of death (Ite	m 23a) (Tvne	Print)	1049	1	vecember	21 2004		
0			SAMBANDAM BAS	KALAN, 34	STh	LKENS	AVE,	BALTI	MORE, 1	21 2004 21 2124		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) UEC 2 2 20	32. Registrar's Sign	ature	Carr.						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 14 7:05 PM George Patrick Shultz 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11014 Carriage Lane Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Dete of Birth (Month, Day, Yeer Mar. 17, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 70 Illinois 328-26-6506 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
The marked other than "natural", or items 23e or 28e-f show any or other them "natural" are marked the marked have a marked to have the market will find all my or other treumatic event. The Medical Engine. 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Directo Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11014 Carriage Lane 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M2 Yes 2 □ No If Yes, Give Year or Dates: 1951-55 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert T. Shultz Frances Bedwell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul T. Shultz - Son 6432 Erin Dr., Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. injury or St. Peter's Cemetery 12/17/2004 Libertytown, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 11802 Liberty Rd. 21. Signature of Funeral Service Licenses affaur Libertytown, MD 21762 Hartzler Funeral Home 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MENTSTANC CHICER **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Prostage carter Completed Asbestosii exposue 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 Yes 2/2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3□ DOA this 27. Magner of Teath 28d. Fescribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After t 1/ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai (Check only one) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D40307 2000 JL asaena 30. Name and address of person who completed cause of deith (Item 23a) (Type, Print) Eugene B. Casagrande 1564 Opossumtown Pike Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 0 2004 Registrar

			State of Maryland / Der	partment of Health and Mental Hy	
			1 - State Registrar C6	artificate of Dooth	giene 004 42325
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  John W. Smith	2. Date of De. Month	Pay Year Chill
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Н			Doctor's Community Hospital.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Lanham  y) If Under 1 Year   If Under 24 Hrs.   8. Date of Birt	Prince George's
ı	Funeral Director		251-60-8625 № 2□F 63 Yrs.	Moπths Days Hours Min. (Month, Day	y, Year) 9. Birthplace (State or Foreign Country) 2 1941 S. Carolina
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	Location	10d. Inside City Limits
	Mary a-f sh	tor	Maryland Prince George's Sprince	rdale	YQYes 2 ☐ No
	ith the	Director	10e. Street and Number		10g. Citizen of What Country?
	s 23a		4009 91st Avenue	20774	USA 14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumetic event, it is Medical Exam, including a notified at ODGe.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>Yes 2☐xNo Specify:</li> </ol>	Black, White, etc.  Specify: Black
Maryland 21215-0036	2 hour	ted k		pedent's Usual Occupation we kind of work done during most of working	16b. Kind of Business/Industry
212	thin 7: e	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	NA KING OF WORK GONE GUING MOST OF WORKING  DO NOT use retired)	
7	led wil			vy Equipment Operator	
and	d be find He double of other	Be	17. Father's Name (First, Middle, Last)		Maiden Sumame)
Ž	should nd Me mark metic	To	Jessie Smith  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	Ruby Lake iling Address (Street and Number or Rural Route Number	ır, City or Town, State, Zip Code)
Š	alth ar		Marie T. Smith (Wife) 4003	9 91st Ave. Springdale	. Md. 20774
or G	of He		20a. Method of Disposition 20b. Place of Disposition cemetery, or	rematory or other place)	20c. Location - City or Town, State
Ĕ	Pag tment tent: I		'4 □Donation 5 □Other (Specify) Zion Chi	hn's Ame urch Cemetery 12/23/04	Odenton, Md.
Baltimore,	Sermit Separ Mpor Mny in		I was a summer to	22. Name and Address of Facility  Mm. Reese & Sons Mortu	ary, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	821 West St. Annapolis	Md. 21401
	Physician				Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Rupture And Due to (or as a consequence of):	anew ysuc	minutes
	Examiner		il. a extensi	on	yeuus
	ed sit	niner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
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760	icate be physicial s the buri	cail	d		
89	leath certificate attending phy ifor use as the	Medi	IF FEMALE:		
Вох	attend for use	Physician/Medi	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3	B Ectopic pregnancy	23d. Date of delivery  Month Day Year
o.	the de	ysic	1 Yes 2 No 9 Unknown	5 ☐ Other (specify)	
۵.	res that the de igned by the a be detached f	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
rds	w requires been sig should b			101	es 2 No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	as be	Completed		24a. Was autop	sy prior to completion of cause of
<u>~</u>	Physicien: The lav this certificate has al director, page 2	Con		perfo 1 ☐ Yes	med? death? 2 No 1 Yes 2 No
Žį.	sicien certifi rector	o Be	25. Was case referred to medical examiner?  1	26. Place of Death (Check only o	
ō	y Phys er this eral di	H :	27. Manger of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Describe h	now injury occurred
on	ttending Phi death. ctor: After thi / the funeral o	atio	1. Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division of		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location (S City or Tow	Street and Number or Rural Route Number, n, State)
	pitel o		29a. Certifier Certifying Physician: To the best of my knowledge, de.	ath occurred at the time, data and place, and due to the	cause/s) and manner as stated
	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b	Medical	(Check only one)    Check only   2   Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	To the within To the Complex c	Me	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
1			Henry Remson MD	019446	DECEMBER 30, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e Print)	
			STEVEN LEMSEN M. D. 575 MAIN  31. Date filed (Month, Day, Year)  32. Paistrar's Signature.	STIREET, SUITE 351 LAN	EL MO 2010/
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 1 2004  32. Restrar's Signature	Sperk	

04-8120 B.K.S	
FLOYD D.	

OYD D. T	AYL	OR 1 - State Registrar	State of Maryla		artmen rtificate			nd Me	ntal Hy	giene Reg. Noc	2001	423	26
Physic	ian	1. Decedent's Name (First, Middle, L	ast)				-		2. Date of De Month	eath _ Day	Yeer	3. Time of Do	
/Med Exam	ical	Floyd Dickson  4a. Facility Name (If not institution, g SOUTHERN MARYLAN)		TER	4b.CLY	TOTOK	Location of		DEC.	17,	2004 County of De RINCE	1509 GEORGES	Рм
Funera Directo				rs. last birthday,	If Under Months	1 Year Days	If Under 2	Min.	Date of Bi	rth ay, Year)		irthplace (State or F Country) IL	ore ig.
the Maryland r 28a-f show	'n	Usual Residence of Decedent  10a. State 10b. County		City, Town or L								10d. Inside City	
or 28a-	Director	Virginia Fairfax  10e. Street and Number	K AL	exandri	10f. Zip	Code				10g. Citiz	zen of What C	Country?	
.0036 hours after death with the Maryland tural', or tems 23a or 28a-f show al Examiner must be notified at	by Funeral	5828 Biscayne Dr: 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	223 Was Deced If Yes, spec	lent of Hi of Cuba	spanic Origi n, Mexican, Specify:	in? (Speci Puerto Ri	ty Yes or No	0-	ed Stai 14. Race - Am Black, Wh Specify: W	nerican Indian, nite, etc.	
215-	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education Irade completed)  College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done a	urina most (	of working	1	16b. Kir	nd of Busines	s/industry	
Ind 212 be filed withing tal Hygiene. Id other then event, the M	Be Con	12 17. Father's Name (First, Middle, Las		Tech	nician		18. Mother	s Name (	First, Middle			nd Coolin	g_
irylan should be nd Mental marked o matic eve	To	Floyd Dickson Ta  19a. Informant's Name/Relationship	-	19h Maili	ing Address	(Street a			Louise		his r Town, State,	Zin Code)	
1 a a L		Andrew Dickson T	aylor, Son	921	Carria	ige I	1111 R	oad '	Virgir	nia B	each,	VA 23452	
TOTE,  ages 1 al ent of Hea nt: If item y or othe		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	A removal from State	p. Place of Dispo cemetery, cre uantico			De	cember 200	er 28,		cation - City o	Virginia	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any injury or other		21. Signature of Funeral Service Co				d Addres	s of Facility	Fair	fax Me	emori	al Fun	eral Home VA 22032	ļ
rnysiciar /Medica Examiner		23a. Part1/Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Cause, Disease or injury	a. Due to (or as a cons	ENON C								Approximate Interval Betwe Onset and Dea	
de fou, cate be executed physician and the burial-transit	dical Exar	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):									
.O. BOX 6 the death certific ty the attending of	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3[	⊒Ectopic pro ☐ Other (sp					2	3d. Date of de Month	elivery Day Yea	ır
rdS, P quires that n signed b	ed by PI	Part II. Dther significant conditions	contributing to death but not	resulting in the u	underlying ca	ause give	n in Part I.			tobacco us		to the cause of dea Probably 4 Honk	
	Completed										24b. Were a prior to death?	autopsy findings ava completion of causes	ilable e of
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	XER/Outpatie	ot 3□ DO	Othe	er.		Check only		i □Other (Spe	aniful	
VISION OF Attending Physic death. ector: After this by the funeral di	tlon: To	27. Manner of Death  1 Matural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year			8c. Injury Work	7 14013	28	d. Describe			өспуу	
DIVISION al or Attending a after death. Il Director: Afte	Certification:	3 Suicide 6 Could not determine		t home, farm, st	reet, factory	, office		28		(Street and wn, State)		Rural Route Numbe	;
To the Hospital or within 24 hours afte To the Funeral Directions of the Completely filled in the Funeral Directions of th	edical C	29a. Certifier (Check only one)  1 Certifying F	Physician: To the best of my le eminer: On the basis of exam and manner stated.	knowledge, deal ination and/or in	th occurred avestigation.	at the tim in my op	e, date and inion, death	place, an occurred	d due to the at the time,	cause(s) , date and	and manner a place, and du	as stated. ue to the cause(s)	
To the within 2 To the complet	Me	29b. Signature and title of certifier	me Shell	W		O.C	number .M.E			29d. Date	_	nth, Day, Year) 2004	
(b)		MARYAMAS A.	o completed cause of death (I	111 PEN		EET,	BALT	IMORE	E, MARY	LAND	21201		
S Regis	tate trar	31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature									

			1 - For State State Registrer		artment of Health and tificate of Death	Mental Hygie	211116	42327
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici	7	Amos M. Teegarden			Month December	Day Year 17. 2004	10:15 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and n	umber)	4b. Cily, Town, or Location of Dea	1	4c. County of Dea	
	LXaimin		Montgomery Hospice-Cas	ev House	Rockville		Montgome:	rv
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hr Months Days Hours Mir	S. 8. Date of Birth	9 Bir	thplace (State or Foreign ountry)
	Director		183-30-4610 1 <sup>2</sup> M 2□F	65 Yrs.	Months Days Hours Mil			nsylvania
	p .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	show	7						1 Tyes 2 No
	Ba-f	Director	Maryland Montgomery	Betheso		140	022 (141) + 0	
	F or S	Dir	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry ?
	sath	eral	5711 Kingswood Court	cedent Ever in U.S. 13. \	20814  Was Decedent of Hispanic Origin?		USA 14. Race - Ame	arican Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland It of Health and Mental Hygiene.  If item 27 is marked other then "naturel", or Items 23s or 28s-1 show or other treumatic event, The Medical Evanirar must be notified at the contraction of the contraction	by Funeral	Armed F	Forces? I 2 2 2 No Give	f Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, Whit	e, etc.
21215-0036	2 hou	ted	15. Decedent's Education	16a. Deced	lent's Usual Occupation	16b	. Kind of Business	/Industry
215	hin 7:	Completed	(Specify only highest grade completed Elementary/Secondary (0-12)  College	(Give life. I	kind of work done during most of w DO NOT use retired)	orking		
21;	d with	Com	12		rier		Postal Se	ervice
pu	al Hy l othe	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Maid	den Sumame)	
/lai	uld b Ments rrked	To	Frank Teegarden		Mae S	anner		
Maryland	2 sho and ! is me		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street and Number or F	Rural Route Number, Ci	ty or Town, State, a	Zip Code)
≥ .	and and n 27		Lorinda L. Teegarden/		Kingswood Court,			
ore	Og = 0 H		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □ Removal from	20b. Place of Dispo cemetery, cren		ember 21	. Location - City or	Town, State
Ë	Pag ment ant: ury c		' 4 □Donation 5 □ Other (Specify)	Parklawn Me				Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then enty injury or paher treumatic event, ILM Magnee.		21. Signature of Funeral Service Licence		Pame and Address of Facility Tancis J. Collir O University Bly			g, Ma 20901
8			23a. Part1. En er the visease, or complications that shock, or heart tallure. List only one cause on	caused the death. Do not ent	er the mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between
易	Physician		Immediate Cau a (Final		tic Adenocarcino	aram.		Onset and Death
7	/Medical			o (or as a consequence of):	LAG AMENDECLERA	a Ur I		470
8	Examiner		Sequentially list conditions, b.					
	Sit 9d	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):				
	and -tran	xam	that initiated events c	o (or as a consequence of):				
8760,	death certificate be executed attending physician and of for use as the burial-transit	ai E		(01 20 2 001100 017.				
687	phys the	dicai	d					
	leath certific attending p	/Me		utcome of pregnancy			23d. Date of de	livery
Box	atter atter I for u	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year
Ö.	that the de led by the a detached i	nysi	9 Unknown 9 Unk	nown				
٥.	requires that the een signed by thi tould be detache	by Pl	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
Records,	quire; n sig	d be				1 🗆 Yes	2 □ No 3 □ Pr	robably 4 🛣 Unknown
00	> 0 10	Completed				24a. Was an	24b. Were au	utopsy findings available
	The lav	mo				autopsy performed 1 ☐ Yes 2 🛣	? death?	completion of cause of
Vital		BeC	25. Was case referred to medical		26. Place of De	eath (Check only one)	140 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2010
<u>&gt;</u>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No Hospital:	Inpatient 2 ER/Outpatien	t 3 DCA Cther: 4 Nursing	Home 5 ☐ Residence	6¥□Other (Spe	cify) Hoenics
) of	g Physier this			e of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		Ticapite
Ö	Attending r death. ector: After by the fune	atio	2 Accident investigation	, 22,732,7	M 1 ☐ Yes 2 ☐ No			
Division	r Atte er de recto	Certification:	3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At home, farm, str ding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St		ural Route Number,
	itel or rs afte el Dir	Cer						<u> </u>
	To the Hospitel or Attending Phywithin 24 hours after death.  To the Funerel Director: After thi completely filled in by the funeral or	Medical	(Check only 2 Medical Examiner: On the	ne best of my knowledge, death basis of examination and/or in unner stated.	n occurred at the time, date and place vestigation, in my opinion, death occurred.	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	7	29c. License number	29d.	Date signed (Mont	h, Day, Year)
	7		Claure		0412	18 1	2/17/	04
-			30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print)		1 /	
			Charles Harrison, M.D		ter Mill Road, R	ockville, I	Md 20855	
	Sta		31. Date filed (Month, Day, Year)  DEC 2 1 2004	Registrar's Signature	Sporks			
	Registi	ar	DEC & 1 2004	/- /-				

			Please •	Type or Print in Black I State of Maryland / Dep		•	•	1.000
			1 - Stata Registrar	Ce	ertificate of Death		Reg. No. UU4	42328
	Physici /Medic		Decedent's Name (First, Middle, Last     Godfrey			2. Date of Dea	Day Year	3. Time of Death 4 0655 M
	Examir		4a. Facility Name (If not institution, give	1 Miles / 1/2	4b. City, Town, or Location of Death	1	4c. County of Dea	
			5. Social Security Number 6. Se	11100	JAUISBURY  V) If Under 1 Year   If Under 24 Ars.	8. Date of Birt	Hiom	
	Funeral Director			DM 2⊠F 92 Yrs.	Months Days Hours Min.	(Month, Day	17, 1912 Mai	thplace (State or Foreigr ountry) cyland
	Aaryland F show	or	10a. State 10b. County	10c. City, Town or				10d. Inside City Limits 1 Yes 2 □ No
	or 28e-	Funeral Director	Maryland Wicomic  10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	sath v	erai	629 North Park Dr		21804	necity Yes or No-	USA 14. Race - Ame	arican Indian
326	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I then 27 le marked other then "natural", or Items 23a or 28e-f show other traumatic event, the Modical Extended that the infilted at	by Fun	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 □ Yes 2 [X] No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert     □ Yes 2 No Specify:	o Rican, etc.)	Black, Whit	
21215-0036	n 72 hou "natura	leted	15. Decedent's Ed (Specify only highest grad	ucation 16a. De (Girde completed)	cedent's Usual Occupation ve kind of work done during most of wor . DO NOT use retired)	king	16b. Kind of Business	
N	filed withii Hygiene. other then ent, the M	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)  3 Nurs	se		Medical	
	ould be fi Mental H larked ot latic ever	Be	17. Father's Name (First, Middle, Last)				Maiden Sumame)	
Ž	2 should and Men le marke aumatic	To.	George Filmer  19a. Informant's Name/Relationship (7	Godfrev Type, Print) 19b. Ma	iling Address (Street and Number or Ru	Mae Iral Route Numbe	Dickerson or, City or Town, State, J	Zip Code)
മ്	1 and 2 s Health ar em 27 le ther trau		John K. Williams	20b. Place of Dis	edar Point Road, Se	everna P	ark, Maryla	
nor	ages ant of it; If it y or o		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	iematory or other place) Iemonial Pank Decembe	r 22 2001	Salisbury	
Baltimore,	permit. Pages Department of I Importent: If ite eny injury or of		21. Sign us e of Emeral Service Licens		22 Name and Address of Facility Holloway Funeral I	Home Pro	fessional A	Association
	-nysician /Medical		23a. Part 1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)		501 Snow Hill Road inter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
	Examiner	-	Sequentially list conditions,	b. Due to (or as a consequence of):				
	be executed sician and burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
	icate be ex physician s the burial	ā		d				
.O. Box 6	ath certif attending for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		B Ectopic pregnancy		23d. Date of del Month	livery Day Year
ds, P.	ires that the de signed by the a d be detached t	by	Part II. Other significant conditions co	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to	o the cause of death?
Records,	e law requir has been si je 2 should l	Completed				24a. Was autop	sy prior to	utopsy findings available completion of cause of
<u>e</u>	iician: The l certificate ha rector, page					perfor 1 ☐ Yes		2□ No
Vital		o Be	25. Was case referred to medical examiner?	: Hospital: ★Linpatient 2☐ER/Outpat	Othor	th (Check only of		
o		<b>-</b>	1 Yes 22-No.  27. Manner of Death 1 Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at		lence 6 Other (Spe low injury occurred	city)
Division	ten leat tor; the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28f. Location (S City or Tow	Street and Number or Run, State)	ural Route Number,		
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier  (Check only 2   Madical Exam	ysician: To the best of my knowledge, de niner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occurred.	, and due to the o	cause(s) and manner as	s stated.
	the I	Medical	one)  29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Mont.	
)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	-	Delp 7		D603657		12/20/0	, Jay, 16a1)
	10/10		30. Name and address of person who co	completed cause of death (Item 23a) (Typ		DELD	R SALIS	GURY WID
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 2 1 200	32. Registrar's Signature	560 RIVERS			21801

			1 - For State Registrar	State of Maryla		artment of H tificate of I			iene 00	4 1	+2329	
	Physici /Medic		Decedent's Name (First, Middle, Las     WILLIAM	I F. WALKER				2. Date of Death December	r <b>1</b> 7, 20	1 <del>0</del> 4	3. Time of Death 07:28 Рм	
	Examin		4a. Facility Name (If not institution, give Memorial Hospital	street and number)		4b. City, Town, or Easton	Location of Deat	th	4c. County of Talbot			
	Funeral Director		5. Social Security Number 216-30-4617 1.  Usual Residence of Decedent	9x 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year)	Country	ce (State or Foreign	
	within 72 hours after death with the Maryland ene. than "naturat", or Items 23s or 28s-1 ehow ha Madical Exemirer must be notified at	ector	10a. State 10b. County MD Talbot  10e. Street and Number		City, Town or Lo	cation 10f. Zip Code		1/	g. Citizen of Wh		. Inside City Limits 1 ☐ Yes 2 ☐ No	
	ath with \$ 23a or	Funerai Director	29380 Will Street			21601		1	USA			
980	ours after de rat', or Items Examinar n	by	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2  No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	American White, etc		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: it item 27 is marked other than "naturat; or items 23s or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupi kind of work done o DO NOT use retired Worker	during most of wo	rking	6b. Kind of Busin		stry	
Maryland 2	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) George Lee Walker				18. Mother's Nat Frances	me (First, Middle, M s Crose	faiden Sumame)			
	nd 2 sho aith and 27 Is mu r trauma		19a. Informant's Name/Relationship (7) Catherine A. Lurto					ural Route Number, Ston, MD		ate, Zip Co	ode)	
Baltimore,	Pages 1 arment of Heanant: If item		20a. Method of Disposition  1  Burial 2  Cremation 3  Other (Specify	Removal from State M	. Place of Dispo		θ)	Date 2	loc. Location - Ci lexandria		n, State	
Balt	permit. Departi Import any inj	V 3	21 Signature of Funeral Service Cen	seQ	Ce	. Name and Addres dar Hill Fu	ss of Facility 41 neral Home	l11 Pennsylv e,Inc.	vania Ave,	Suitla	and,MD 20746	
68760,	Live be executed / Medical Examiner   Medical	dical Examiner	28a. Hart1. Enter the disease, or compensions, or heart failure. List only of the condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. First Locations of the conditions a. Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	equence of):	NJ WRIE		c or respiratory arre	St,	In	pproximate terval Between nset and Death		
P.O. Box 68	death certifi le attending ad for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of predictions of the second of the	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month		ıy Year	
	sign d be	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribu		cause of death?	
al Records,	The ate ha	Completed						24a. Was an autopsy gerform 1 Yes 2	ed? prio	or to-compl	r findings available elion of cause of	
Division of Vital	To the Hospital or Attanding Physicien: The within 24 hours after death.  To the Funeral Director: After this certilicate completely tilled in by the funeral director, page.	Certification; To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)	4 613	28c. Injury Work	ar: 4 ☐ Nursing H	28d. Describe how	th (Check only one)  ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  OF STRUCION VENTOR Number,  28f. Location (Street and Number or Rural Route Number,  City or Lown, State)			
	Hospit 24 hour Funera etely tille	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my liner: On the basis of exam	nowledge, death ination and/or inv	occurred at the time restigation, in my or	e, date and place pinion, death occu	e, and due to the cau urred at the time, dat	use(s) and mann	er as state	ed. e cause(s)	
)	To the To the comple	Me	29b. Signature and title of certifier	morton	CN	29c. License	Ε.	D	d. Date signed (A	18,	2004	
	De		30. Name and address of person who			Penn Stre	eet, Bal	timore, M	aryland	2120	1	
	Sta Registr		DEC 2 2 2004	32. Registrar's Sig	gnature							

			For State	State of		d / Depa				and M	lental Hyg	iene			
			Registrar			Cei	rtificate	of L	Death			eg. N6.	1004		2330
ı	Physicia	an	Decedent's Name (First, Middle,	Last)							<ol><li>Date of Dea Month</li></ol>	Day	Yea	r	me of Death
ı,	/Medic		Gladys Evelyn 1								December				45 a M
1	Examin	ęr	4a. Facility Name (If not institution,	give street and nun	nber)		4b. City, I	own, or	Location o	f Death		4c.	County of De	ath	
_			Bedford Court  5. Social Security Number		Home 7. Age (In yrs.	last birthday)	Sil If Under		Sprin		8. Date of Birth		lontgor		tate or Foreign
	Funeral Director		223-62-3838	1□ M 2□xF		2 Yrs.	Months	Days	Hours	Min.	(Month, Day Feb. 12	Year)	12 501	Country)	tate or Foreign
	ס		Usual Residence of Decedent								100. 12	, 13	12  000	ich bu	KOCU
	nrylan show	_	10a. State 10b. County			y, Town or Lo									de City Limits
	Ba-f e	cto		gomery	S	Silver	-								Yes 2X No
	or 2	Director	10e. Street and Number				10f. Zip				1	0g. Citi	zen of What	Country?	
	s 23e	rai	3700 Internat:					0906				-	USA		
	ler de	Funerai	11. Marital Status	Armed For		S. 13.	Was Decede If Yes, speci	ent of Hi fy Cubai	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ar Black, W		an,
36	Irs aff	by F	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	If Yes, Give	e TATTAT T		1 ☐ Yes 2	X No	Specify:				Specify: W	nite	
21215-0036	within 72 hours after death with the Maryland one. then "neturel", or Items 23e or 28a-f ehow then "neturel" or Items 23e or 28a-f ehow the Maryland at the Itelified at		15. Decedent's	Education			dent's Usual						nd of Busine:		
215	hin 7	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	4or 5+)	(Give life.	kind of worl DO NOT us	k done d e retired,	luring most )	of worki	ng				
21	d wit	Completed		3		Home	emaker					Ow	n Home	•	
	al Hy al Hy 1 oth	Be (	17. Father's Name (First, Middle, L.	ast)					18. Mothe	r's Name	(First, Middle, I	Maiden	Sumame)		
yla	ould to Ment arked etic	10	John Febuel N	ichols					Chri	stin	e Nelson	1 			
Maryland	2 sh and Is m		19a. Informant's Name/Relationshi			1	-				d Route Number	-		, Zip Code)	
	l and fealth im 27 ther t		Joyce Wilsie G	ross/ Dau							Bowie, I			Town Cha	
Baltimore,	in of H		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation :		ו שוסוכ	lace of Dispo emetery, crer			1.		ber 29		cation - City		
ij	ritanita in Parameter Para		'4 □Donation 5 □Other (Special)		Met	ropolita	-			20			andria	, Vir	ginia
Ba	perniti. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f ehow any njury or other treumetic event, the Modical Examiner must be inclined at once.		21. Signature of Fundal Service Li	Cerisee							Funeral				1 00003
m			23a. Part1. Enter the disease, or o	omplications that ca	aused the death						d, W, S:		r Spri		d 20901
Ж	20		shock, or heart failure. List o Immediate Cause (Final	nly one cause on ea	ach line							JO.,		Interva Onset	il Between and Death
	Pnysician /Medical		disease or condition resulting in death)	- William	Stage Consequence		ive H	leart	: Fail	lure				2 We	eks
	Examiner			Coro	nary Ar		); cosc	_						Many	Vone
	展	ē	Sequentially list conditions, if any, leading to firm odiate cause. Enter Underlying Cause (Disease or injury		or as a consequ		Tacas							escre by	20050
	cuted	mir	Cause (Disease or injury that initiated events	c											
o,	be executed iician and burial-transit	cai Examiner	resulting in death) Last	Due to (	or as a conseq	uence of):									
3760,	ite			d											
89 ×	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE:									1			
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		rth 2 Feta	death 3	Ectopic pre					2	3d. Date of o	lelivery Day	Year
<u>o</u>	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□ Unkno	ant at time of di wn	eath 5L	Other (spe	cify)						,	
۵.	law requires that the as been signed by th 2 should be detache	Ph	Part II. Other significant condition	s contributing to de	ath but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did tot	acco u	se contribute	to the cause	e of death?
ds,	sign d be	d by		· ·			, ,					s 2[			4 📆 Unknown
Record	w require been sig should t	Completed									24a. Wasa	n	24h Wara	autonsy find	ings available
Re	o _ c _ g	ф									autops	y	prior to death	completion	of cause of
Vita	icien: Th certificate rector, pag	e Cc	25. Was case referred to medical						OC Diago	of Dooth	1 Yes 2		1 🗆 Y	es 2 No	
	Physicien: r this certificaral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Dir	npatient 2	ER/Outpatier	it 3□ DO/	Othe			n <i>(Check only on</i> me 5 ☐ Reside		□Other /Sr	necify)	
o	ding Phy h. After thi funeral c		27. Manner of Death	28a. Date o	f Injury h, Day Year)	28b. Time of		c. Injury Work	at		28d. Describe ho			ociny)	
Division	Attending or death.  ector: After by the fune	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		i, Day rear)	Injury	М		' 'es 2 □ N	No					
<u> </u>	or Attend after death Director: /	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Place	of Injury - At ho	ome, farm, str	eet, factory,	office		1	28f. Location (St City or Town			Rural Route	Number,
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Cer													
	To the Hospitel within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1  (Check only 2   Medical E	Physician: To the xaminer: On the ba	best of my kno	wledge, death	n occurred a	t the tim	e, date and	d place, a	and due to the ca	ause(s) ate and	and manner place, and d	as stated. ue to the cau	ıse(s)
	the hin 2 the the mplet	Med	one)	and mann											
	To To Con	-	29b. Signature and title of certifier			-	290.		number 3202				signed (Mo mber ]		-
,	10		20 Name and add			NA.	<b>S</b>								
	10		30. Name and address of person w					ງ່ອນ	re Wor	r1d	Blvd, Si	100	r Spri	na M	d 20906
	1					JUG DUL	حاسا دناء	-cul			vu, D_	-	T NATT	I'I	
	Sta	te	31. Date filed (Month, Day, Year)  DEC 21		gistrar's Signa		Spa							37	u 20300

				For State	State of M	aryland	d / Depa	rtment of H	Health and N	Mental Hy	_	14 42331	
				1. Decedent's Name (First, Middle,	Last)		<u> </u>	inicale of	Dealii	2. Date of D		3. Time of Death	
		Physici /Media		Ruth Jane Willi	n					Decer	nber 18	Year 2004 0351 M	A
		Examir		4a. Facility Name (If not institution,	, ,	)	111	•	or Location of Death		4c. County		
				101111	on of Medi	CM L	ensu	If Under 1 Year	1/364Nf	10.00		Conico	
-		Funeral Director		5. Social Security Number 221-10-4170	. Sex 7. Ag 1 ☐ M 2 🛣 F	ge (In yrs. 18 83	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of B (Month, D Dec. 1	0,1921	9. Birthplace (State or Foreign Country) Mary Land	ก
2		p		Usual Residence of Decedent		1.0.00							
7		ahow	7	10a. State 10b. County  Maryland Wicomi	00		, Town or Loc ptown	cation				10d. Inside City Limits 1 X Yes 2 □ No	
-	5	the M	rect	10e. Street and Number		Dilai	ptown	10f. Zip Code			10g. Citizen of W		
10	7	h with	Funeral Director	302 Nanticoke S	treet			21861			USA		
65	Z	r deat	Iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13. V	Vas Decedent of H Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	o- 14. Race Black	e - American Indian, k, White, etc.	
22	36	d within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f ahow tre Medical Esacil as crimit be redified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		i	☐ Yes 2 No				White	
	5-0036	2 hou natura	Completed by	15. Decedent's	Education		16a. Deced	ent's Usual Occup	pation		16b. Kind of Bu	siness/Industry	
	7	within 7 iene. than "r	npie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)		_	oation during most of worl d)	King	0 11	_	
	121	Hyg tha nt,	CO	12 17. Father's Name (First, Middle, La	(Sf)		Homen	laker	18 Mother's Nam	na (First Middle	Own Home		
118	lan	be d all all all all all all all all all a	To Be	Waitman Ralph Wi							Wheatle		
Willer	Maryland		-	19a. Informant's Name/Relationship	(Type, Print)				and Number or Rui				_
7	e,⊠	s 1 and 2 should f Health and Men item 27 Is marka othar traumatic		Patricia A. Kie	f/Daughter	20h BI		McGrath	Road, Ed	en, Mar <sub>Date</sub>			
17	nor	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or othar trai		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		Ce	metery, crem	atory or other pla	<sub>сө)</sub> Сет. 12/21			City or Town, State	
ити	Baltimor	mit. Poartme		21. Signature of Juneral Service Li	ensee 0	1			ess of Facility neral Home				
0	ä			Server	S all	er			Street, E				
			(	2 a. P. 11. Enter the disease, or composition ock, or heart failure. List or	phplications that cause one cause on each li	d the death ine.	. Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory	arrest,	Approximate Interval Between Onset and Death	
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a5	epsi	5				-		
		Examiner			Due to (or as	a consequ		mous t	regues	201			
		₽ #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ			0				
		xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):						
	68760,	tificate be executed g physician and as the burial-transit	sal E		d	a comboqu	31100 317.						
			Aedical	12.551111.5	u								
	Вох	eath certif attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal	death 3 🗌	Ectopic pregnanc	y		23d. Date Mon	of delivery th Day Year	
	P.O. I	the the	by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	ath 5□	Other (specify)	.*			an Day Total	
		ires that the signed by do be detact	y Ph	Part II. Other significant condition	s contributing to death b	out not resu	tting in the un	derlying cause giv	ven in Part I.	23e. Did	tobacco use contri	bute to the cause of death?	
	ords	w require been sig should b	ted t		OPD					1 🗆	Yes 2□No	3 Probably 4 Unknown	ı
	ecc	alaw n nasbe e 2 sh	Completed	0	BHD A-	1-				24a. Was	s an 24b. W	/ere autopsy findings available rior to completion of cause of	)
	al H	ysician: The is certificate hiddirector, page								perf 1 ☐ Yes		eath?  Yes 2 No	
	Zi.	siciar certif	o Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital:	opt 3 🗆 E	ER/Outpatient	3□ DOA Ott	26. Place of Deal		one) idence 6 🗆 Othe	. (0	
	J Of	ding Phys n. After this funeral di	n; To	27. Manger of Death	28a. Date of Inju	ury	28b. Time of Injury	28c. Injur			how injury occurre		
	sior	utending Ph death. ctor: After th / the funeral	catic	1 Accident 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion			M 1 🗆	Yes 2 □No				
	Division of Vital Records,	l or At after d Direct in by	Certification;	4 Homicide determin	ad 280. Place of In	jury - At hor tc. (Specify,	me, farm, stre )	et, factory, office		28f. Location City or To	(Street and Numbe iwn, State)	r or Rural Route Number,	
	_	To tha Hospital or Attendi within 24 hours after death To tha Funaral Director: A completely filled in by the fi			Physician: To the best								_
		tha Honin 24 tha Fu	Medical	one)	aminer: On the basis of and manner st	ated.	on and/or inv			red at the time			
		To To	4	29b. Signature and title of certifier	1-10			29c. Licens	se number		29a. Date signed	(Month, Day, Year)	
				30. Name and address of person wi		death (Item	23a) (Type. F	Print)	6125		10110	717	
	_			TON, CONSTANTE	1340 5	- Divi	sion s	t sal	isbuy,	NO			
		Sta Registr		31. Date filed (Month, Day, Year) DEC 2	0 2004 A	ar's Signati	ure	books	0	-			

				For State Registrar			nd / Depa		Health and M	lental Hygi	9	) L <sub>1</sub>	42332
				Decedent's Name (First, Middle,	Last)					2. Date of Death	J. NO.		3. Time of Death
_		Physici		Francis Ed	ward Wri	oht.				Month 12		eer 2004	0534 M
		/Medio		4a. Fecility Name (If not institution,				4b. City, Town, o	or Location of Death		4c. County of		
		ZAGIIII		PENINSULA REGI	WAI ME	dial 1	2014	1	1413644		Hic	omi	co
		Funeral		5. Social Security Number	. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Dec. I		9. Birthola	ace (State or Foreign
		Director		218-07-6270	1 <b>□</b> M 2□F	8	34 Yrs.	Months Days	Tiodis iviit.	Dec. 1,	1920	Mary	land
	1	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	ocation				10	d. Inside City Limits
D,		Maryland f show ied at	or		0 10 000		•						1. These 2 □ No
7	7	ith the Marylar or 28e-f show se notified at	rect	Maryland Dorche	ster		Ca	mbridge		100	g. Citizen of Wh	at Count	rv?
X3		3e or	D	103 Willis Stre	et			2161	3	, 0,	g. O. 112011 O. 11111	USA	
~	0	be filed within 72 hours after death with the Maryla ital Hygiens that the first that do the than "naturel", or flems 23e or 28e-1 show event, the Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.		Hispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No-	14. Race -	America	
SS	9	after or Ite	Fu	1 Never Married 2 Marrie	Amed For 1 1 Yes If Yes, Gi	2 No	1	1 Yes, specify Cub 1 ☐ Yes 2 ☑ No	_	Rican, etc.)		White, et	tc.
KK	93	ours rel',	d by	3 Widowed 4 Divorced	Year or E		TT		•		Specify:	Wh	nite
Francis Eduxina	21215-0036	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done	oation during most of work d)	ing 16	8b. Kind of Busin	ness/Indu	ıstry
. 3	121	within lene. than	du	Elementary/Secondary (0-12)	College (	1-4or 5+)					_		
20	d 2	Hygie Hygie ther	ပိ	17. Father's Name (First, Middle, La	ist)	_	⊥∪wner	/Operato		(First, Middle, Ma	Transp	orta	ation
na	<b>E</b> 3	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, the M	To Be	Martin E. Wri						a Outten	,		
	7	d 2 should be th and Mental 7 Is marked o traumatic eve	F	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Number or Rura		City or Town, St.	ate. Zip (	Code)
17		and 2 ealth a n 27 Is		Mrs. Jean Wright	/Spouse		103	Willis S	treet, Car	mbride.	MD 216	13	
. 30	ē, 5			20a. Method of Disposition	<u>*</u>	20b. I	Place of Dispo	sition (Name of natory or other pla	ce)		c. Location - Ci		n, State
Wright	E			1 🕒 Burial 2 □ Cremation 3  `4 □ Donation 5 □ Other (Spe					 1Park12/1:	1/2004	`ambrid	e. N	Maryland
	Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Li	censee	A.			ess of Facility OMWeII Fu				al j land
	<b>m</b> 8	2052		Stobled Dol	rat-	Emu	vell:	OS High	St Camb	neral Hon	ne, P.A. 21613		
				23a. Part 1 Pater the disease, or coshock, or heart failure. Ist of	omplications that	cansed the dear	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	21013	í	Approximate nterval Between
	P	hysician		Immediate Cause (Final disease or condition		Por		U VESC	Son A	aiden	/		Onset and Death
		/Medical Examiner		resulting in death)	Due to	(or as a consec		/	1 1	10			sugo
		-xamme	L	Sequentially list conditions,	b	Ath	CVOS	dero	tec nea	A (nse	24		
	7	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consec	quence ot):						
	100	and and II-tran	хап	that initiated events resulting in death) Last	c	(or as a consec	uence of):					_	
	760,	ate be executed sysician and he burial-transit	cai E	A Company		,	,						
	687	ricate phys s the			d								
	Box (	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy				23d. Date of	of delivers	,
	m §	death s atte d for	iciai	in the past 12 months?	4☐Pregi	oirth 2 🗍 Feta nant at time of c		Ectopic pregnancy Other (specify)	¥		Month		ay Year
	P.O.	t the by the ache	hys	9 □ Unknown	9□ Unkn	own							
	S, E	ss tha gned se det	by P	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribu	ite to the	cause of death?
	of Vital Records,	en sig								1 ☐ Yes	2 □ No 3 (	_ Probab	oly 4 🗍 Unknown
	BCC B	as be	Completed							24a. Was an autopsy	24b. Wei	re autops	sy findings available of
	<u>a</u>	the ete h page	Com							performe	d? _ dea		
	/ita	ertific ector,	Be (	25. Was case referred to medical examiner?						(Check only one)			
	) t	this o	2	1 ☐ Yes 2 ☑ No			ER/Outpatier		4 LI Nursing no	me 5 ☐ Residend		Specify)	
	) Li	After Unera	lon:	27. Manner of Death  1 Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe how	injury occurred		
	Sic	death death tor: , the f	icat	2 Accident investiga 3 Suicide 6 Could no	be On Bloom	at laine. At h	ome form the		Yes 2 □ No	204 Lacation /Ctra	at and Number	- Oursell	D
	Division	or A after of Direction by	Certification:	4 ☐ Homicide determin	ed 286. Place build	ing, etc. (Specil	ome, rarm, str (y)	eet, factory, office		28f. Location (Stre City or Town,	et and Number ( State)	or Hurai F	Houte Number,
	-	spital ours nerel filled	aj C	29a. Certifier 1 Certifying	Physician: To the	e best of my kno	wiedge, death	occurred at the tir	me, date and place,	and due to the caus	se(s) and mann	er as stat	ed
	7	To the Hospital of Atlanding Phylacian: The law requires that the death Certifica within 24 hours after death.  Within 24 hours after death.  The Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edicai	(Check only 2 Medical Ex	aminer: On the b	asis of examina	ation and/or in	estigation, in my o	pinion, death occurr	ed at the time, date	and place, and	due to th	he cause(s)
		withir To th comp	M	29b. Signature and title of certifier	_ 1			29c. Licens	se number	29d	. Date signed (A	Aonth, De	ey, Year)
					Ke	· ·		200	32212	/.	2/16	109	
				30. Name and address of person w	no completed cau	se of death (Iter	n 23a) (Type,	Print)			1 7		
				STEPHEN KEI	m	PRMC		JALISBO	uey, Mo	1 218	01		
		Sta Registr		31. Date filed (Month, DECar2	0 200432.	Registrar's Signa	ALUIFO ALUIFO	book	32212 ULY, M				

	1	For State Registrar	State of M	aryland	/ Depa	artmen rtificat	t of H e of L	ealth a Death	ind M	lental I	Hygiei Reg.	line U	)4	423	33
Physician	8	1. Decedent's Name (First, Middle, Las Ruby Cordell W				-				2. Date of Month Dec.		Day 2004	Yeer	3. Time of 0	Death M
/Medical Examiner		ta. Facility Name (If not institution, give Chester-River Ho	street and number)			4b. City,		Location o		DCC.	13,	4c. County Ken		1 0000	
Funeral Director	- 1	5. Social Security Number 6. Se		e (In yrs. Ia:		If Under Months		If Under a		8. Date of (Month	Day, Ye		9. Birthp	olece (State or ntry) nsylvar	Foreign 1ia
Maryland f ehow		Usual Residence of Decedent  10a. State 10b. County  Morry 1 and Vant		10c. City,	Town or Lo									0d. Inside City	y Limits
with the Maryland or 28a-f show		Maryland Kent				Worto	Code				10g.	Citizen of V		ntry?	
urs after death verified at the state of the	Di allona	24944 Lambsmead  11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 Pr If Yes, Give Year or Dates:	_	ĺ	Was Deced If Yes, spec		spanic Orig n, Mexican	gin? (Spi , Puerto	ecify Yes or Rican, etc.	No-	14. Race	k, White,	ean Indian, etc.	
- 22 -	2001	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or!	5+)	16a. Deced (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ition Juring most	of work	ng	16b	. Kind of Bu			
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mar	ב ב	12 17. Father's Name (First, Middle, Last)	4		Super	visor		18. Mothe			ldle, Maid	ty Go len Sumam	e)	ment	
nd 2 should be file 127 is marked oth 17 is marked oth 17 or marked	2	Arthur C. Young,  19a. Informant's Name/Relationship (7	ype, Print)			-			r or Rura	l Route Nu	mber, Ci	rnett	State, Zip	Code)	
of Health	-	Wister James Wint  20a. Method of Disposition  1 Burial 2 Octopation 3 2	/	20b. Pla	ce of Dispo	sition (Nar matory or o	ne of ther place	9)		Wort	20c	Location -	1678 City or To	own, State	
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic ance.	i	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service) Licens	Niche	Ar	lingt							nsauk , P.A 2161		NJ	
law requires that the death certificate be executed as been signed by the attending physicien and a should be detached for use as the buriat-transit  bleted by Physician/Medical Examiner	30	23a. Rant Enter the disease, or composition, or heart failure. List only of the second	ilications that caused the cause on each life.  a. CARDO Due to (or as b. Due to (or as c. Due to (or as d	a conseque	Do not ent  MON  ence of):  C R  ence of):	er the mod	e of dying	, such as	cardiac	r respirato	y arrest,			Approximate Interval Betwo Onset and De	reen
at the death certifice of by the attending pretached for use as the prescription.	) Sicilaria in in in in in in in in in in in in in	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal o	leath 3□	Ectopic pr Other (sp					_	23d. Date Mor		,	9ar
quires that the n signed by ald be detaced by Phrese	2	Part II. Other significant conditions co	entributing to death b	ut not result	ting in the u	nderlying c	ause give	n in Part I.				_		ne cause of de ably 4 ⊟Un	
The law requir										. P	has an utopsy enformed as 2 12	?_   d	eath?	psy findings av	vailable use of
hysician: The his certificate all director, pag	2	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆 E	R/Outpatier	nt 3 DC	Othe			(Check or		6 □Othe	or (Specifi	()	
. E E =   L		27. Manner of Death  1 Natural 5 Pending investigation		y Year)	28b. Time of Injury	f 2	8c. Injury Work 1 🗆 Y					lury occurr		,	
itel or Attending P irs after death. ral Director: After ited in by the funera		3 Suicide 6 Could not be determined	building, et	c. (Specify)						City or	Town, St	ate)		l Route Numbe	ar,
To the Hospitel o within 24 hours at To the Funeral D completely filled in Medical Cel		(Check only 2   Medical Exem	vsician: To the best iner: On the basis o and manner st	f examination	ledge, deat! on and/or in	vestigation	, in my op	inion, deat	d place, h occurr	and due to ed at the tir	ne, date a	and place, a	ind due to	the cause(s)	
To t To t com		29b. Signature and title of certifier	lied fr	M-13	) ±		License		-9			Date signed			
State Registrar		30. Name and Iddress of person who control of the ATE PATS 31. Date filed (Month, Day, Year). DEC 2 0	AL IN		, 22	Print)	tigh	Stre	ct,	(Hes	Lant	iwn	m	4 210	20

			1- For Amend Item Registrar	State of M 23a,PtII	laryland/Deper Dr.,&	epartment o 840 .02/0 ertificate	f Health 05dh of Deal	and M	ental Hyg	giene 2 (	004	42331	
, 6	Dhusisi		1. Decedent's Name (First, Middle, La.	st)		-			2. Date of Dea Month		Yeer	3. Time of Death	
	Physici /Media		RU JING YE						Novemb		2004	10:15 A <sup>M</sup>	
	Examir	er	4a. Facility Name (If not institution, give		)		m, or Locatio er Spr				y of Deeth 1tgome	<b></b> .	
		-4	Holy Cross Hosp  5. Social Security Number 6. S		ge (In yrs. last birtho			er 24 Hrs.	8. Date of Birth	1		lace (State or Foreign	
	Funeral Director			<b>⊠</b> ⋅M 2□F	90 Yr	Months   D	ays Hours	Min.	(Month, Day July 2	, Year)	Cour	ntry)	
1	P.		Usual Residence of Decedent		140.00								
	arylar	_	10a. State 10b. County		10c. City, Town o		0				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	he M	Director	D.C. None		wasni	ngton, D				l0g. Citizen of	What Cour		
	with i	눕		NT TT								itty :	
	leath	Funeral	800 6th Street	12. Was Deceden	t Ever in U.S.	200 13. Was Decedent	of Hispanic (	Origin? (Spe	city Yes or No-	U . S . A	ce - Americ	can Indian,	
ထ	or Itar		1 ☐ Never Married 2 Married	Armed Forces		If Yes, specify			Rican, etc.)		ick, White,		
03	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show arral Exp. unst. das Le mullied at	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 □ Yes 2🎞	No Speci	ny: 		Specia	fy: Asia		
21215-0036	72 h netu	Completed	15. Decedent's Ed (Specify only highest gra		(0	ecedent's Usual O Give kind of work d	one durina m	ost of workii	ng	16b. Kind of E	Business/In	dustry	
121	within lene. than "	ф	Elementary/Secondary (0-12)	College (1-4or	5+)	fe. DO NOT use n School T				Educ	ation		
<b>d</b> 2	led lygi ther nt,	0	17. Father's Name (First, Middle, Last,		5	Denoor 1		ther's Name	(First, Middle,				
lan	lid be fental rked ilc ev	To B	Chong Hen Ye				F	u Lai	ng Li				
Maryland	es 1 and 2 should be for Health and Mental I fitem 27 is marked of gother traumatic ever		19a. Informant's Name/Relationship (	Type, Print)	19b. N	failing Address (St	reet and Num	ber or Rura	l Route Number	r, City or Town	, State, Zip	Code)	
Σ.	and 2 ealth n 27 I		Kuo Jen Yip/Son			2 Landow			-		-		
Baltimore,	H iter		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from State	cernetery,	isposition (Name of crematory or other	place)		ate	20c. Location	- City or To	own, State	
Ë	tmen tant:		' 4 □ Donation 5 □ Other (Specif	-	George	Washingt			/2004	Adelph:	i, Ma	ryland	
Ba	permit. Pages 1 Department of H Important: If ite sny injury or ot		21. Signature of Funeral Service Licer	Ve cen	tre		NALDI w Hamp	FUNER shire			Sprin	g, MD 20904	
	Physician /Medical Examiner	niner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fairers. List only one cause on each line.  Immediate Cluse (Final disease or condition resulting in death)  Sequentially list conditions, I say learn to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
Box 68760,	death certificate be executed e attending physician and nd for use as the burial-transit	hysiclan/Medical Exar	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	_d 23c. If yes, outcom 1□Live birth	2 Fetal death	3 ☐ Ectopic pregn					ate of delive	ery Day Year	
0	that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐Unknown	at time of death	5 ☐ Other (specif	v)						
S, D	Se La	by P	Part II. Other significant conditions of Chronic Obstruc	_	_		e given in Pai	rt I.				ne cause of death?	
Record	> 10 0	Completed	Chronic Renal I	nsufficie	ncv. <del>Aspi</del>	ration			24a. Was a		Were auto	psy findings available	
Re	0 4 0	mo	Coronary Artery						autops perform	med?	death?	mpletion of cause of 2□ No	
Vital	ician: Th certificate ector, pag	0	25. Was case referred to medical	Disease			26. Pla	ice of Death	(Check only on			20110	
<u>_</u>	ys die	To B	examiner? 1 □ Yes 2 🖾 No		ient 2 ER/Outpa	atient 3 DOA	Other: 4 🗆	Nursing Hor	ne 5 ☐ Reside	ence 6 □Ott	ner ( <i>Specif</i> )	y)	
ion of	ling After fune	ertification;	27. Manner of Death  1 ☑Natural 5 ☐ Pending  2 ☐ Accident investigation		ay Year) 28b. Tim Inju		Injury at Work? 1  Yes 2		28d. Describe ho	ow injury occur	rred		
Division	or A or A Direction by	Certiflo	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of I	njury - At home, farm atc. <i>(Specify)</i>	, street, factory, of	fice	2	28f. Location (Si City or Town		ber or Rura	l Route Number,	
	To the Hospital or within 24 hours afte To tha Funeral Discompletely filled in	edical	29a. Certifier 1 ☑ Certifying Ph (Check only one) 2 ☐ Medicel Exer	nysician: To the bes niner: On the basis and manner s	t of my knowledge, of examination and/oitated.	death occurred at the investigation, in	ne time, date my opinion, d	and place, a eath occurre	and due to the co	ause(s) and m ate and place,	anner as st and due to	ated. the cause(s)	
	To the To the comp	Ž	29b. Signature and title of certifier	A 1	4		cense numbe	r	2	9d. Date signe	(Month,	Day, Year)	
	8		Mulay	thalle	Ellen, N.	D00	57639		1	2/16	120	04	
	U		30. Name and address of person who Anuradha Arun,				St 1v	er Snr	ing. Ma	rvland	2090	2	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	-		DPI					
100 W	Regist		DEC 21 2	004 Der	wa p	Span	KN						

		1	For State Registrar	State of	Marylar Marylar		artmen rtificat			nd M	ental Hyg	iene	200	L L	2335
	ysicia Medica	n İ	Decedent's Name (First, Middle, Last)     Edward			Zucke	rman			}	2. Date of Deat Month Decembe	Dav	9,2004	r	Time of Death 2:25A M
	amine	-	4a. Fecility Name (If not institution, give Heritage Harbour			b.Ctr.	,	Town, or	Location of	Death			ounty of De	eth Arun	del
Fun Dire	eral ctor		5. Social Security Number 6. Set		7. Age (In yrs. <b>85</b>			1 Year Days	if Under 24 Hours	Hrs. Min.	8. Date of Birth (Month, Day, June22	Year)	9. E		State or Foreign
a Maryland	iffed at		Usual Residence of Decedent           10a. State         10b. County           MD         Anne Ar	undel		ty, Town or Lo									side City Limits
with the	Lie no	Dire	10e. Street and Number 2514 Tudo Cour	· †			10f. Zip	Code 21401				0g. Citize	on of What	Country?	
d within 72 hours after death with the Maryland dwithin 72 hours after death with the Maryland sidene. Then "natural", or Items 23a or 28a-f ehow in then "natural", or Items	al Examiner nua	by Fur		Armed Fo. 1 X Yes If Yes, Giv Year or Da	dent Ever in Urces? 2 No e ates: WW		1 🗆 Yes	2 <b>X</b> No	Specify:	n? (Spe Puerto f	cify Yes or No- Rican, etc.)	S	Black, Williams	hite, etc. Vhite	
od within 72 hours af giene. er then "natural", or	the Medic	Completed	(Specify only highest grad		-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired	furing most o	of workir	ng		tistry		
Marylatio	event.	To Be C	17. Father's Name (First, Middle, Last)  Benjamin Zuck	erman						s Name nnah	(First, Middle, I Levy		umame)		
Hear Hear	any injury or other traumatic		19a. Informant's Name/Relationship (Ty  Lorraine Zuc.  20a. Method of Disposition  1 □ Burial 2X2Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	kerman	State	2514 Place of Dispo cemetery, createry, createry	Tudo psition (Name and Control of	ne of other place	urt A atory s of Facilin	12/2 Old	21/04 Town F	aryle 20c. Loca Alex unei	and ation - City and ri ral Cl	21401 or Town, S ia, V hoices	tate irginia
>	iner tisusit	Exam	23a. Pant1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (	or as a consector as	quence of):	al some	de of dyin	g, such as ca	Muon	respiratory arro	est,		Inten	oximate val Between et and Death
hat the death certific by the attending p	detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	come of pregn irth 2   Feto ant at time of cown	el death 3	⊒Ectopic p ⊒ Other (s <sub>i</sub>				· · · · · · · · · · · · · · · · · · ·	23	d. Date of d Month	delivery Day	Year
law requires that the	pe pe	Š	Part II. Other significant conditions co	ntributing to de	eath but not re	sulting in the u	inderlying (	cause give	en in Part 1.	_		oacco use			se of death?
The The	page 2 should	Completed									24a. Was a autops perform	y	24b. Were prior t death 1 \( \text{ Y}	o completio	ndings available on of cause of
Physician: The		o Be	25. Was case referred to medical examiner?	Hospital:		Teno		Oth	200		(Check only on		Tau (2		
5 £ £	funeral di	-1	1 Yes 2 No  27 Manner of Death  1 Natural 5 Pending 2 Accident investigation	leath 28a. Date of Injury 28b. Time of Injury at Work?    Sometime							ne 5 Reside 28d. Describe ho			pecity)	
DIVISION  el or Attending s after death. el Director: Afte	ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place buildi	of Injury - At h	nome, farm, st	reet, factor	y, office		2	28f. Location (St City or Town	reet and n, State)	Number or	Rural Rout	te Number,
To the Hospitel or within 24 hours after To the Funerel Dire	pletely fill	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exerni	ner: On the b											ause(s)
# 8+1	com	Ž	29b. Signature and title of certifier	len			29	c. Licens	number 4051	19	2		signed (Mo		
			30. Name and address of person who co					n Co	urt (	Crot	fton Mar	vlar	nd .	21114	
D.	Stat		31. Date filed (Month, Day, Year) <b>NFC.</b> 21 20	32. F	egistrar's Sign	ature &		arks				,			

		1. Decedent's Name (First, Middle	e, Last)			1		2. Date of	Death		3. Time of Death
Physici: Medic/		Renee		ena-Obama				Decem	ber 2	25, 2ď%	06:52 A
Examin	er	4a. Facility Name (If not institution Prince George!	n, give street and num s Hospital	<sub>nber)</sub> 1 Center	4b. Ci	ity, Town, or I Cheve	Location of De erly	eath		c. County of Death rince Geo	
uneral irector		5. Social Security Number 215-71-0752	6. Sex 1 ☐ M 2√☐ F	7. Age (In yrs. last b	Yrs. If Uni	der 1 Year hs Days 25	If Under 24 H Hours M	8. Date of (Month,	Birth Day, Year	unk 9. Birth Cou Ma	oplace (State or Fore Intry) ryland
NOW III		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location						10d. Inside City Lim
r 28a-f show rediffed at	Director	Maryland Prince	George's			Bowie	·				1 ☐ Yes 2√1
23a or 2	al Dir	10e. Street and Number 2961 November	Ct.		101.	Zip Code 20716			10g. C	itizen of What Cou U.S	
l', or items narciner m	by Funeral	11. Marital Status  1. XX Never Married 2 ☐ Marr  3 ☐ Widowed 4 ☐ Divorced	Armed For	2X No	If Yes, s	cedent of His specify Cuban s 2 XNo	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - Amer Black, White AsbacinyCan	
r than "natural". The Medicul En	Completed I	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t's Education	16	a. Decedent's U (Give kind of life. DO NO	work done du	tion uring most of v	vorking	16b. I	Kind of Business/II	ndustry
other the	Com	N/A		N/A			N/A			N/	'A
c even	Be	17. Father's Name (First, Middle, Louis V. Aben					18. Mother's N Dafro	lame (First, Mide	dle, Maide yirwa	,	
item 27 is marked othe other traumatic event,	2	19a. Informant's Name/Relationsl Louis V. Abena	hip (Турв, Print)				nd Number or	Rural Route Nui	nber, City	or Town, State, Zi	ip Code)
item 27 other t		20a. Method of Disposition		20b. Place	of Disposition (A	Name of	Do	ec.Date31.	-	nd 20716 Location - City or T	own, State
ant: If ury or		1		state _	rection	ı Cemet	rer√ 20	004	C1i	nton, Ma	ryland
Important: If item 27 is eny injury or other tra		21. Signature of Funeral Pervice	al m	00257					ral H	lome, Inc	ton. MD20
sician edical		Immediate Cause (Final disease or condition resulting in death)	Sudder	n Unexplai	ined Dea			iac or respirator	/ arrest,		
edical and prize p	ical Examiner	disease or condition	a. Sudder  Due to (c)  Due to (c)	ach line.	ined Dea				y arrest,		Interval Between
edical alternating physician and process as the burial-transit	edicai	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate sauss. Enter Underlying Cause (Disease or injury that initiated events	a. Sudder  Due to (c)  c. Due to (c)  d.  23c. If yes, outc	or as a consequence or as	ined Dea	regnancy			y difest,	23d. Date of deliv Month	Interval Between Onset and Death
god by the attending physician and understand to use as the burial-transit understand to use as the burial-transit understand the understand	by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate base. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	a. Sudder  Due to (c)  c. Due to (c)  d.  23c. If yes, outce 1  Live bite 4 Pregnary 9 Unknown	or as a consequence or as	ined Dea e of): e of): th 3   Ectopic 5   Other	c pregnancy (specify)	Infanc	23e. Di	d tobacco	Month use contribute to t	Interval Between Onset and Death  Pery Day Year
has been signed by the attending physician and in police 2 should be detached for use as the burial-transit in police.	by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate bass. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Sudder  Due to (c)  c. Due to (c)  d.  23c. If yes, outce 1  Live bite 4 Pregnary 9 Unknown	or as a consequence or as	ined Dea e of): e of): th 3   Ectopic 5   Other	c pregnancy (specify)	Infanc	23e. Di 1[ 24a. W	d tobacco	Month  use contribute to to the second secon	ery Day Year  the cause of death?  bably 4 □Unkno
certificate has been signed by the attending physician and Grector, page 2 should be detached for use as the burial-transit Grector.	Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate bass. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Sudder  Due to (c)  b. Due to (c)  c. Due to (c)  d. 23c. If yes, outcome to the pregnance of the pregnan	or as a consequence or as	ined Deale of):  a of):  b of):  th 3   Ectopic   5   Other   in the underlying	pregnancy (specify)	Infanc	23e. Di 1[ 24a. W au 1 PYes	d tobacco  Yes 2  as an topsy formed? 2 \ No	Month  use contribute to to the contribute to th	ery Year  Day Year  the cause of death?  bably 4 Unkno
After this certificate has been signed by the attending physician and Groneral director, page 2 should be detached for use as the burial-transit Groneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Sudder  a. Due to (c)  b. Due to (c)  c. Due to (c)  d. 23c. If yes, outcome to the control of the control o	or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence of pregnancy or the 2 Fetal death and at time of death with the consequence of pregnancy or the sequence of the se	ined Dea e of): e of): th 3   Ectopic 5   Other	c pregnancy (specify) g cause given	Infanc	23e. Di 1[ 24a. W au 1 PYes	d tobacco  Yes 2  Bs an topsy formed?  2 □ No one	Month  use contribute to to the contribute to th	ery Year  Day Year  the cause of death?  bably 4 Unkno
After this certificate has been signed by the attending physician and Groneral director, page 2 should be detached for use as the burial-transit Groneral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Sudder  a. Due to (c)  b. Due to (c)  c. Due to (c)  d. 23c. If yes, out  1   Live bi  4   Pregna  9   Unkno  ons contributing to de  Hospital: 1   In  28a. Date o  (Month latton not be ined  28e. Place a  buildin	or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence of pregnancy or the 2 Fetal death and at time of death with the consequence of pregnancy or the sequence of the se	ined Deale of):  e of):  th 3 Ectopic 5 Other of the underlying th	c pregnancy (specify)  g cause given  DOA Other 28c. Injury a Work? 1 □ Ye	Infanc	23e. Di 10 24a. W au 10 10 10 10 10 10 10 10 10 10 10 10 10	d tobacco Yes 2 as an topsy formed? Cone one insidence is how injuited.	Month  use contribute to to the contribute to th	Interval Between Onset and Death Onset and Death Personal
After this certificate has been signed by the attending physician and Groneral director, page 2 should be detached for use as the burial-transit Groneral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Budder  a.  Due to (a)  b.  Due to (a)  c.  Due to (a)  d.  23c. If yes, outcome to be a contributing to de a contributing to de a contribution on to be a contribution on to be a contribution on the building Physician: To the backwisers on the backwisers.	or as a consequence or as	ined Deale of):  e of):  th 3   Ectopic   5   Other   in the underlying    Dutpatient 3   Time of unk   Injury   Marm, street, factorice   Due, death occurrence   Due, death	c pregnancy (specify)  g cause given  Other  28c. Injury a Work?  1  Ye  ory, office	Infanc  in Part I.  26. Place of D  4 \( \text{Nursing} \)  at date and pla	23e. Di  24a. W  24a. W  24b. Ves  28d. Describ  28f. Location  City or T  Bowie,	d tobacco  Yes 2  as an topsy formed? cone usidence e how inju  (Street an own, State  Mary  Be cause(s	Month  use contribute to to the contribute to th	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death?  Day Year Onset and Jeney Control of Cause of Control of
Iter this certificate has been signed by the attending physician and Iteration in a second the detached for use as the burial-transit Iteration in a second be detached for use as the burial-transit Iteration in a second in the	To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate sause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (c) b. Due to (c) c. Due to (c) d.  23c. If yes, out 1   Live bi 4   Pregnt 9   Unkno  ons contributing to de  Hospital: 1   In 28a. Date o (Montt) juition not be loud  g Physician: To the	or as a consequence or as	ined Deale of):  sof):  sof):  th 3 Ectopic 5 Other (	c pregnancy (specify)  g cause given  Other  28c. Injury a Work?  1  Ye  ory, office	Infanc  an in Part I.  26. Place of D  4 Nursing at each planion, death oc	23e. Di  24a. W  24a. W  24b. Ves  28d. Describ  28f. Location  City or T  Bowie,	d tobacco  Yes 2  as an topsy formed? 2 \( \) No one sidence e how injuit  (Street an own, State  Mary  ne cause(se, date an own, date an own, date an own)	Month  use contribute to to the contribute to th	Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?  Day Year Onset and Death?
After this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit of the principle of the	Certification; To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate sause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Budder  a.  Due to (a)  b.  Due to (a)  c.  Due to (a)  d.  23c. If yes, outcome to be a contributing to de a contributing to de a contribution on to be a contribution on to be a contribution on the building Physician: To the backwisers on the backwisers.	or as a consequence or as	ined Deale of):  a of):  b of):  th 3   Ectopic   5   Other    outpatient 3   I in the underlying    outpatient 3   I ime of unk   Injury   Marm, street, factore    ence   ge, death occurre   and/or investigation    2	c pregnancy (specify)  g cause given  28c. Injury a Work? 1 Ye ory, office	Infance  an in Part I.  26. Place of D  4 \( \text{Nursing} \)  at  by  date and pla  nion, death ocnumber	23e. Di  24a. W  24a. W  24b. Ves  28d. Describ  28f. Location  City or T  Bowie,	d tobacco  Yes 2 as an topsy formed? 2 No one insidence in the court of the court o	Month  use contribute to to the contribute to th	Interval Between Onset and Death Onset and Death

State of Maryland / Department of Health and Mental Hygiene

_		C	ertificate of Death	Reg. No. 1004 42337
	Physician	1. Decedent's Nama (First, Middle, Last)  M. Harvey BROWN		2. Data of Daath  Month Day Year 11:00 AM
	/Medical			December 21, 2004
	Examiner	4a Facility Name (If not institution, give street and number)  Hebrew Home of Greater Washing	4b. City, Town, or Location Rockvil	7.1.2.2.
	Funeral	5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthda		8. Data of Birth (Month, Day, Year)  9. Birthplaca (State or Foreign Country)
	Director	113-12-4055 1 M 2 F 95 Yrs.  Usual Rasidance of Decedant	Months Days Hours Min.	March 6, 1909 New York
	yland	10a. Stata 10b. County 10c. City, Town or		10d. Insida City Limits
	e Mar	Maryland Montgomery	Chevy Chase	1 □ Yas 2 ဩ No
	death with the Maryland oms 23a or 28s-f show I must be notified at neral Director	10e. Street and Number 4215 Leland Street	10f. Zip Coda 20815	10g. Citizan of What Country? United States
	death death	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas?	3. Was Decedant of Hispanic Origin? (Spei If Yes, specify Cuban, Maxican, Puarto F	cify Yas or No- lican, atc.)  14. Race - Amarican Indian, Black, Whita, atc.
020	urs after death value 234 Exeminer must by Funeral	1 ☐ Nevar Marriad 2 ☑ Married 1 ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: WW II	1 ☐ Yes 2 X No Specify:	Specify: white
15-0	led within 72 ho lygiene. The than "naturn It, the Medical Completed	15. Decedant's Education (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of workin b. DO NOT use retired)	16b. Kind of Business/Industry
121	within sne.	Elamantary/Secondary (0-12) Collega (1-4or 5+)	o. <i>DO NOT</i> use retired) ified Public Account	
d 2	Hygie Hygie of the Co	17. Father's Nama (First, Middle, Last)		tant Accounting (First, Middle, Maiden Surname)
lan	Mental H Mental H arked oth artic even	Joseph Braunstein		Zimmerman
$\sim$ Baltimore, Maryland 21215-0020	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once.  To Be Completed by Funeral Director		ailing Address (Street and Number or Aural 5 Leland Street, Che	Poute Number, City or Town, State, Zip Code) evy Chase, MD 20815
ore,	of Hee	20a. Method of Disposition 20b. Placa of Discemetery, cometery, co	sposition (Name of rematory or other place)	2 Pate 3 / 04 20c. Location - City or Town, State
tim	Page ment of lury or	LALBUTIAN 2 L.J.Cremation 3 LARemoval from State		emetery Washington, DC
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OWN	40244		254 Carroll St., NW	
2 C	Dhysisian	23a. Part1. Enter the disaasa, or complications that caused the daath. Do not a shock, or heart failure. List only ona cause on each line.	inter the mode of dying, such as cardiac or	r raspiratory arrest, Approximate Interval Between Onsat and Daath
0	Physician /Medical	Immediata Causa (Final	AL THROMB	0015
> 1	Examiner	disaasa or condition resulting in death)  Dua to (or as a cons		.03/2
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	igned be dat			75 123 22.10
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Jec	The law requir sata has been s page 2 should			completion of cause of death?
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0	g Phy ter thi neral	27. Mannar of Death 28a. Date of Injury 28b. Tima	of 28c. Injury at 28	8d. Describe how injury occurred
siol	eath. or: Af the fu	2 Accident investigation	M 1 □ Yas 2 □ No	
Division of Vital Records,	or Att after d Direct In by	4 Homicide  determinad  428e. Place of Injury - At home, farm, s building, atc. (Specify)	street, factory, office 28	8f. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospital or Attending Physician: The law requires that the death c within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attanc completaly filled in by the funeral director, page 2 should be datached for us Medical Certification: To Be Completed by Physician.	29a. Certifier (Check only (Ch	ath occurred at the time, date and place, ar	nd due to the causa(s) and manner as steted.
	thin 24 thin 24 the Fu mpleta	one) and manner stated.		
	1 vit	29b. Signature and this of centifiar	29c. Licansa number 1) / \$1) \$-1	29d. Data signed (Month, Day, Year)  DECEMBED 2 1 2 00 4
	0	30. Neme and addrass of person who completed causa of dag/h (Item 23a) (Type	e Print)	DCCC1111 R 21 2007
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	State Registrar	31. Data filed (Month, Day, Year)  DEC 2 2 2004  32. Ragistrar's Signatura	Sparker	

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Physician (Medical Cause (Final Line) and Cause (Final Line) as a consequence of):    Physician (Medical Cause (Final Line) and Cause (Fi	nor	ages nit of No. If it		1   Burial 2 □ Cremation 3	Removal from State	cemetery, crer	natory or other plac	· · · · · · · · · · · · · · · · · · ·				
Physician (Medical Cause (Final Line) and Cause (Final Line) as a consequence of):    Physician (Medical Cause (Final Line) and Cause (Fi	altir	artme ortan injur			See A	ING DAVID	MEMORIAL  Name and Addre	SS of Facility	12/19/04	FALLS	CHURC	CH, VIRGINI
Physician // Medical Examinor    Physician // Medical Examinor   Physician // Ph	ä	Der Imp		1 amanda	Ludonir		ANZANSKY 170 ROCK	GOLDBERG	E MEMORI	AL CHAP	FL, 201	§\$2
Physician (Micelical Examiner)   Micelical Examiner   Micelical Examin				23a. Part1. Enter the disease, or comp	lications that caused the	ne death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate
Due to (or as a consequence of):    Sequentially list conditions   Sequentially list conditio				disease or condition	. He	morrh	1901	51	roke			Onset and Death
Souther lay in the past 12 months?    Female   F	1			resulting in death)		consequence of):	J		7			agys
Due to (or as a consequence of):    Security of the part of the pa			-	Sequentially list conditions,	b. Due to (or as a		15101					
Due to (or as a consequence of):    Security of the part of the pa		uted d ansit	min	cause. Enter Underlying Cause (Disease or injury	200 10 (0. 40 4	001100 01).						
FEMALE:   23b. Was deedednt pregnant   1   1   1   1   1   1   1   1   1	0,	an an rial-tr	ш	resulting in death) Last	Due to (or as a	consequence of):						
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Part II. Uther significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?	O.		iysic			ne of death 5	Other (specify)				,,,,,,	Jay 16al
25. Was case referred to medical sexaminer?  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Place of Death (Check only one)  2		s that ned by deta		Part II. Other significant conditions co	ntributing to death but	not resulting in the un	iderlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to the	cause of death?
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25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death Natural of the property o	ပ္သ	aw re	plet						24a. Was	an 24b.	Were autop:	sy findings available
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The state of the control of the co	/ita	cian: ertific ector,	a	examiner?				26. Place of Dea				. [2] 140
Natural 2   Accident 3   Suicide 4   Homicide 5   Pending investigation 6   Could not be determined 28b. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Matthew Pofferoth Mil 9901 Medical Center 10   Center 10	of	ys dis	F +	1 165 20110	Inpatient		3LI DOA	4   Nursing H	ome 5 Resid	dence 6 □Oth	er (Specify)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30 Signature and address of person who completed cause of death (Item 23a) (Type, Print)  Mathew Pofferoff Mill 990 Medical Carter Signature  31 Date filed (Month, Day, Year)  32 Acction (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mathew Pofferoff Mill 990 Medical Carter Down Cockulte Month (Item 23a) (Type, Print)  Mathew Pofferoff Mill 990 Medical Carter Down Cockulte Month (Item 23a) (Type, Print)	U <sub>O</sub>		tion	Natural 5 Pending	28a. Date of Injury (Month, Day Y		Work	?	28d. Describe h	now injury occurr	red	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mathew Pofferoth M 9901 Medical Center Divided to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Fegistrar's Signature Medical Center Divided (Month, Day, Year)	/isi	Atten deat octor: by the	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, stre		es 2 🗆 NO	28f Location /9	Street and Numb	or or Puml	Pouto Alumbar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Matthew Pofferoth M. 9901 Medical Center Diver Lockville Mo  State 31. Date filed (Month, Day, Year)  32. registrar's Signature		To th within To th		- A			29c. License	number		29d. Date signed	1 (Month, Da	ay, Year)
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			State of Maryland / Dep.  1 - State Registrar Ce		lental Hygier	•	1,2220
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day 2004 Year	3. Time of Death
	/Medic Examin		David Knight Borges  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	4c. County of Death	
17	Funeral Director			Camp Spring  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		orge's  place (State or Foreign  ntry)  York
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23s or 28a-1 show any injury or other traumatic event, the Modest Exacilinating the notified at Once.	To Be Completed by Funeral Director	10e. Street and Number  2616 Kirtland Avenue  11. Marital Status  1 Never Married Amarried Amender Forces? 1 Never Married Amarried Amender Forces? 1 Never Married Amender Forces? 1 Newer Married Amender Forces? 1 Newer Married Amender Forces? 1 Newer Married Amender Forces? 1 Newer Married Forces? 1 Never Married Forces? 1 Newer Married Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forces Forc	Stville  10f. Zip Code 20747-3510  Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puerto Imparit Companie C	ecify Yes or No-Rican, etc.)  ing  16b.  Fry  al Route Number, City  Forestville  77, 2004 20c.  Clee Funeral	Citizen of What Cou U.S.A  14. Race - Americ Black, White, Specify: Whi Kind of Business/In Governmen en Surname)  y or Town, State, Zige, MD 2076 Location - City or Total tenham Home, Inc.	10d. Inside City Limits  1 Yes 2 No  ntry?  can Indian, etc.  te  idustry  t  cocode) 47-3510  own, State  , Maryland  c.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Coronary Artery Double to (or as a consequence of):  Dischotog Mollitus	isease		ad Clinton	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Diabetes Reflicts  Due to (or as a consequence of):  Renal Failure  Due to (or as a consequence of):  Vasculopathy				
.O. Box 68	The law requires that the death certificate be the has been signed by the attending physic to be 2 should be detached for use as the b	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
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Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ▼ No  Hospital: 1 ★ Inpatient 2 □ ER/Outpatie		h (Check only one) ome 5 - Residence	6 ∏Other (Specif	
ion of	ing After une	<b>—</b>	27. Manner of Death  1 XNatural 5 Pending (Month, Day Year)  2 Accident investigation 28a. Date of Injury (Month, Day Year)		28d. Describe how in		<i>,</i>
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta		al Route Number,
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	To the within 2 To the complete	S	29b. Signature and title of certifier	29c. License number D0016646		cember 21,	
(	2921		30. Name and address of person who completed cause of death (New 23a) (Type Stephen Goldberger, MD 7801 Old Bra	Print) anch Ave. #202 Clin	nton Md	20735	
	Sta Regist		31. Date filed (Month Pax Year) 2 2004 32. Projetrar's Signature	pule	ricon ,	20133	

	-	For State Registrar	State of Maryla		artment of H		nd Menta	al Hygier Reg.		L	42340
		Decedent's Name (First, Middle, Last)						te of Death	Day Y	'ear	3. Time of Death
Physici: /Medic		DANIEL	WESLEY BIGGS	3			DE	CEMBER	22 2	004	8:26 A M
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or				4c. County of		
		315 S. STOKES STR				E DE G		170		RFOR	
Funeral Director		213-16-9098	M 2□F 7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Me	te of Birth onth, Day, Ye 111, 1	ar) 921		ace (State or Foreign try) Jersey
pur A		Usuel Residence of Decedent  10a. State 10b. County	10c. 0	City, Town or Lo	ocation					10	d. Inside City Limits
Maryli f sho	5	Maryland Harf	ord		Havre	e de G	Grace				1X Yes 2 □ No
28a	rect	10e. Street and Number			10f. Zip Code			10g.	Citizen of Wh	at Coun	try?
3a o	Funeral Directo	315 S. Stokes St	reet		2	1078			USA		
deatl	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origi	in? (Specify Ye	etc.)	14. Race - Black.	America White, 6	
ally identice A in A in 200000 should be filled within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show imatic event, the Modical Exertine must be notified at	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:			Specify:			Specify:		
2 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa	ation furing most	of working	16b	. Kind of Busi	ness/Ind	ustry
thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	)					-
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		Millicent Biggs /			S. Stokes						
ore, M es 1 and 2 of Health item 27 I		20a. Method of Disposition	20b	. Place of Disp	osition (Name of matory or other place		Date		. Location - C		
ages ent of ent of rt: If i		1 ∑Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		: United C		12/28/0	)4 E	lavre d	le Gr	ace, MD
Daltimor permit, Pages of Department of the Important: If ite any Injury or of once.		21. Signature of Funeral Service License	67	2	2. Name and Addres	s of Facility	Funera Street,	1 Home	, P.A.		
20290		23a. Part1. Enter the disease, or compli	cations that caused the de	ath Do not en	552 Te	ewis S	Street,	Havre tratory arrest.	de Gr	ace,	MD 21078 Approximate
		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	A11		<b>3</b> ,					Interval Between Onset and Death
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ate be executed hysician and the burial-transit	ũ	resulting in additify case	Due to (or as a cons	equence or).							
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. BOX 687 death certificate e attending phys d for use as the	Physician/Me	in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fr 4 ☐ Pregnant at time o	etal death 3	□Ectopic pregnancy				23d. Date Mont		ry Day Year
The state of the contract of t	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
dS, P.O. ruites that the decrease is signed by the a detached to	by	Part II. Other significant conditions con	ntributing to death but not r	esulting in the	underlying cause give	en in Part I.	2	3e. Did tobac 1 ☐ Yes		oute to th	e cause of death? ably 4 Unknown
Pe 'ee u	Completed						2	4a. Was an	24b. W	ere autor	osy findings available
The law	dwc							autopsy performed ☐ Yes 2	i? de	or to con ath? ⊒Yes	npletion of cause of 2☑No
	Be C	25. Was case referred to medical				26. Place	of Death (Che				
> 5 5 5	To B	examiner? 1 ☐ Yes 2⊠No	lospital: 1 🗌 Inpatient 2	☐ ER/Outpatie	int 3□ DOA Oth	er: 4 □ Nur	rsing Home	Residence	e 6 □Other	(Specify	•)
		27. Manner of Death  1 ✓ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time Injury	Worl	k?		escribe how i	njury occurre	d	
VISION Attending r death. ector: After	catic	2 Accident investigation				Yes 2□N			A sout Mounts	0	/ Courte Momban
DIVISION  I or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s ecify)	treet, factory, office			ity or Town, S		or Hura	l Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exemi	sicien: To the best of my liner: On the basis of examined manner stated.	knowledge, dea ination and/or i	th occurred at the tin	ne, date and pinion, deat	d place, and du th occurred at t	ie to the caus he time, date	e(s) and man and place, ar	ner as st id due to	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d.	Date signed	(Month, I	Day, Year)
->F0		) (Bu	antho	NIS	10	428	00	1	12/2	7/04	/
2		30. Name and address of person who co	ompleted cause of death (I	tom 23a) (Type	Print) AUL	Mis	16.1	la .	2/07	8-	
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	. 7	7-17	1	1	-		
Regist	rar	DEC 2 7 2004	Bearing B	A STORES	Star B						

Mae 729

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. UUL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year DECEMBER 4:42 AM Irma Mae Barnett 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Ceci1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) AUG 3, 193 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign
Country) Months 1 □ M 2 Ϊ F Director 70 215-32-4191 Mary1and Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 17 is marked other than "natural", or Items 23a or 28a-f show traumatic event, it a Madical Examination residence. 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 Fox Den Drive 21921 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and Mental 2 Charles Kinslow Daisy Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Gilbert L. Barnett/Husband 43 Fox Den Drive, Elkton, Maryland 21921 other 20b. Place of Disposition (Name of cametery, crematory or other place)
Griffith AUMP 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State January 3, 4 Donation 5 Other (Specify) Church Cemetery 2005 Cedar Hill, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Apat RESPINATORY DISTITSS Physician SYMONOME disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner INTRA ABDOMINAL SOPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit METASTATIC VTERVEE MUSHA Due to (or as a consequence of) Box 68760. attending physician 99 ian/Medicai as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ted bean Complet 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? this certificate 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 25 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending After Natural 5 Pending after death.

Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 🗌 Homicide within 24 hours a To the Funeral I 29a. Certifier cal 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

106 BOW STREET

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONHAM D.O

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31. Date filed (Month, N

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DLKTON, MD

21921

DEZEMBEN 29 2004

			State of Maryland / Departm	ent of Health and Men	-	
				cate of Death	45	2004 42342
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	/Medic	al	Silas William Bond Jr.  4a. Facility Name (If not institution, give street and number) 4b. (	U	eumber a	19 2004 1.53 FM
	Examin	er		City, Town, or Location of Death  anham		County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	nder 1 Year   If Under 24 Hrs.   a r	Nate of Righ	rince George's  9. Birthplace (State or Foreign Country)
	Director		229-46-3375 65 Yrs.	Ma:	Month, Day, Year) rch 28	1939 Virginia
	ow ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e-f sh	ctor	MD Prince George's Fort Washir	ngton		1 ☑ Yes 2 ☐ No
	or 28	Director	10e. Street and Number 10f	. Zip Code		tizen of What Country?
	eath w	eral	7210 Den Meade Avenue  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was D.	20744		S.A.
	ritem ritem	by Funeral	Amed Forces? If Yes,	ecedent of Hispanic Origin? (Specify specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
2-0036	ours a		3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	es 215 No Specify:		Specify: Black
15-	be filed within 72 hours after death with the Maryland ttal Hygiene. dother then "naturel", or Items 23a or 28e-f show event, the Mudical Exactli et mail te mailified at	Completed	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give Rind of the Rind	Usual Occupation If work done during most of working If use retired)	16b. K	(ind of Business/Industry
12	I within iene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+) Director		Con	ernment
פ	e filed al Hygi other vent, L	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs		
ylar	S should be filed withir and Mental Hygiene. Is marked other then sumetic event, ITEM.	<b>To E</b>	Silas William Bond Sr.		harpe	
Maryland 2121	- C N E		19a. Informant's Name/Relationship (Type, Print)  Dwayne Ramon Bond/Son  13602 T	ress (Street and Number or Rural Roc ree Leaf Ct. Uppe	ute Number, City o r Marlbo	or Town, State, Zip Code) ro, Maryland 20774
Baltimore,	m O - L		20a. Method of Disposition  20b. Place of Disposition  cemetery, crematory	(Name of Date or other place)	20c. Lo	ocation - City or Town, State
Ĕ	permit. Pages Department of Importent: If it eny injury or o		'4 □ Donation 5 □ Other (Specify) Resurrection	Cemeterv 12/30/0	4 Cli	nton,Maryland
Bail	Depart mport my in		21. Signature of Funeral Service Licensee 22. Name	e and Address of Facility J. B.	Jenkins	Funeral Home
	40204	_		4 Landover Road La		Maryland 20785 Approximate
	Physician		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	,	phatory arrest,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	of the Men	to h	474a
	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to forces a cor seq in in it.	metasta	SUS	1 dan
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Z		"
<u>.</u>	certificate be executed ording physician and use as the burial-transit		that initiated events resulting in death) Last c. Due to (or s a consequence of):			
8760	ate be hysicia he bur	cal	d.			
9	ertifica ding pl	Physiclan/Med	IF FEMALE:		1	
Rox	eath certific attending p	clan	IT the past 12 months?	ic pregnancy		23d. Date of delivery  Month Day Year
J.	at the de by the tached	hysi	1   Yes 2   No 4   Pregnant at time of death 5   Other 9   Unknown 9   Unknown	(5,500)/		
	as the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
ecords,	w require been sig should b	Completed	Gente und Joline		1 Yes 2	No 3 Probably 4 Unknown
Hec	The law sate has t page 2 s	mple		2	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital		Ф	25. Was case referred to medical	26. Place of Death Che	Yes 2 No	
	y Sign	To B	examiner?	Other: 4 Nursing Home		6 □Other (Specify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		Describe how injur	
DIVISION	or Attending ster death. Director: After in by the fune	icat	2 Accident investigation M 3 Suicide 6 Could not be	1 Yes 2 No	neation (Street on	of Number of Dural Pouts Number
2	al or Attend after death Director:	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, State	d Number or Rural Route Number, )
	the Hospitel hin 24 hours a the Funerel I npletely filled	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigal	red at the time, date and place, and dr tion, in my opinion, death occurred at	ue to the cause(s) the time, date and	and manner as stated. I place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Med		29c. License number	29d. Dat	re signed (Month, Day, Year)
			/ /m/fame MO	10-20824	12	15/04
2	(10)		30. Name and address of person who completed cause of death (Item 23er) Type, Print)			10 -0 -
	-0:			4.#18 Upper 1	Market	20, MD 20172
	Sta Registr	_	31. Date filed (Month, Day, Year)  DFC 2 7 2004  2. Registrar's Signature—			

Silas William Bord, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22, 2004 **Physician EDWARD** COOPER W. December 3:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbury Rehab & Nursing Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 90 219-36-6297 JULY 12, 1914 MARYLAND Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Examinating the mailtied at 10d. Inside City Limits Director 1X Yes 2 □ No MD WICOMICO WILLARDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7285 CANAL STREET 21874 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "naturel", or ite Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 ASST. MAINTENANCE ENGINEER MD HIGHWAY DEPT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLARENCE COOPER STELLA BRATTEN 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS A. ESHAM P.O. BOX 774, WILLARDS, MARYLAND 21874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐Donation 5 ☐Other (Specify) 12-27-04 NEW HOPE CEMETERY WILLARDS, MD 21. Signature du eral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part I, Enter the disease, or complications that cause shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Mes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2□ No 1 Yes 212 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 No Other: ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State

Registrar

dward

Box 68760

Division of Vital Records, P.O.

William H. Robins, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 2 3 2004

200 Civic Ave., Salisbury, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 19,2004 7:45P M LEE CLARK ROBERT December 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WORCESTER BERLIN NURSING & REHAB. CENTER BERLIN 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR • 31 , 1 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign Days Hours 62 MARYLAND 214-42-8246 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No BISHOPVILLE MARYLAND WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10666 PINEY ISLAND DR. 21813 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates:1963-81 Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INVESTOR REAL ESTATE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CLARK LENA Μ. ROGER GEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10666 PINEY ISLAND DRIVE, BISHOPVILLE, MD 21813 CAROL K. CLARK/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA: 12/21/04 4 □ Donation 5 □ Other (Specify) DELMAR, DELAWARE 21. Signature of Funeral Service License 22. Name and Address of Facility Paus Inter the disease, or complications that cause the doctor of the mode of dying, such as cardiac or respiratory arrest, solicits Course (Tital) HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Betw set and Death Immediate Cause (Final disease or condition neumonia resulting in death) Due to (or as a consequence of): Multiforme blastoma 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 20 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29c. License number

books

Cour tel

29d. Date signed (Month, Day, Year)

12/20/04

**Examiner** Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

signed by

this

After

death.

after death

within 24 hours a To the Funerel C

Physician

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Examiner

by Physician/Medical

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Certification:

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Registrar

31. Date filed (Month, Day, Year)

DEC 2 3 2004

item 27 is marked other than "natural", or items 23e or 28e-f show other treumatic event, Ite Modical Examinational to notified at

filed within 7 Hygiene.

1 and 2 should be 1 Health and Mental I

item 27 l

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permit. Page Department of Important: If any injury or

**Physician** 

/Medical

Maryland 2121 Robert

Itimore,

Bal

clark,

death with the Maryland

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print) dilla 32. Registrar's Signature

			Please		int in Black l /laryland / De			-	•	ible.			
				Otate of h	•	ertificate of		Wiemanny	Reg. No.	04 42345	)		
			1. Decedent's Name (First, Middle, L	.ast)				2. Date of De	eath	3. Time of Death			
	Physici /Medi		Willa M. Carter					Month 12	20	Year 04 12:05 A.M	1.		
	Examir		4e. Facility Name (If not institution, g	ive street and numbe	r)		4b. City, Town, or	Location of Deat	th 4c. County				
			HCR Manor Care			If I lodes 4 Year	Chevy C		Montg				
	Funeral		•	1 TM 2 ME	Age (In yrs. last birthda 87 Yrs	Months Day			rth <i>ay</i> , <i>Year)</i> 7 <b>1</b> 7	9. Birthplace (State or Foreig Country) Greenbay, VA.	ın		
	Director		579-18-3296 Usual Residence of Decedent		07			01 27	1 1	Greenbay, VA.			
	nylanc how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits			
	vith the Maryland or 28e-f ehow be multified at	Director	D.C.		Washir					1. Yes 2 □ No	)		
	with the	Dire	10e. Street and Number	71	,	10f. Zip Code			10g. Citizen of	•			
	72 hours after death with the Maryland neturel', or items 23e or 28e-f ehow iteal Evandrer must be multified at	Funeral	1345 Tuckerman S	12. Was Deceder		2001.		Specify Yes or No	USA	ce - American Indian,			
0	r item	Fe	1 Never Married 2 Married	Armed Forces		Was Decedent of If Yes, specify Cu		rto Rican, etc.)	Bla	ck, White, etc.			
070	ours af	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:	1⊡Yes 2⊠N	o Specify:		Specif	v: Black			
5-0	72 hours "neturel",	eted	15. Decedent's I (Specify only highest g	Education rade completed)	16a. De	cedent's Usual Occ ive kind of work don a. DO NOT use retii	upation e during most of wo	orking	16b. Kind of B	usiness/Industry			
121	J within jiene. r then "I	ld m	Elementary/Secondary (0-12)	College (1-40	(5+)		red)		II C C	overnment			
d 2	P P S	Be Completed	17. Father's Name (First, Middle, Las	2 yrs	• Sup	ervisor	18. Mother's Na	ame (First, Middle					
<u>a</u>	D 5 0 0	To Be	Frank L. Miller				Cora 1	Fears					
Maryland 21215-0020	s 1 and 2 should be f f Health and Mental f item 27 is marked or other treumatic eve		19a. Informant's Name/Relationship	(Type, Print)		alling Address (Stree							
Σ,	12 # Z	(5)	Julia P. Marshall	/POA			n Terr. I			D.C. 20008			
ore	Pages 1 a nent of Hee int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from Stat	20b. Place of Dis cemetery, o	lace)	Date 12-22-04		City or Town, State				
Baltimore,	permit. Pa Departmen Importent: any Injury once.	- 1	4 Donation 5 Other (Spec	-	Marylan	1 Memoria	a.						
Bal	permit. P Departme Importen any Injur.		21. Signature of Funeral Service Lice	ensee O A	0	22. Name and Add							
			23a Part Linter the disease or col	molications that cause				I.W. Washington, D.C. 20011  cardiac or respiratory arrest, Approximate					
	Physician		23a. Part1 Cinter the disease, or conshock, or heart failure. List only	y one cause on each	line.		,,	, , , , , ,		Intervel Between Onset and Death			
J	/Medical		Immediate Cause (Final disease or condition	Sensis	Syndrome								
	Examiner		resulting in death)	а. Ворода	Due to (or as a con:	sequence of):							
	ed sit	ulue	-	Aspira	ation Pneu	monia							
	be executed sician and buriat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a cons	sequence of):							
760,	e be e Siciar e buria	<u>a</u>	that initiated events	c	Due to (or as a cons	seattence off:							
Box 687	eath certificete be exattending physician for use as the buria	Completed by Physician/Medic	resulting in death) Last		Due to (or as a cons	sequence or,							
30X	th cer tendir or use	an		d									
O.	TO 0 0	sici	Part II. Other significent conditions	contributing to death	but not resulting in the	e underlying cause g	given in Part I.	23b. Did	tobecco use co	ntribute to the cause of death	?		
P.O.	requires that the de een signed by the a hould be deteched t	Æ	Cerebrovascular	Accident	Gastrost	omy Tube	Feeds,	1 🗆	Yes 2 No	3 ☐ Probably 4 ☐ Unknow	'n		
ds,	uires ( signe	d b	Diabetes Mellit	ua IIranoma	romaton D	ominhomal		24a. Was	an autopsy	24b. Were autopsy findings			
Ö	~ Q S	lete	Diabetes Mellit	us, nyperi	Lension, F	eripherai		perfo	ormed?	available prior to completion of cause of death?			
æ	0 F 6	E	Vascular Diseas	e				10	Yes 21 No	1 ☐ Yes 2 ☐ No			
ital		Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only	one)				
<u>5</u>	Physiclen: this certific	2	1 ☐ Yes 2 Ñ No	Hospital: 1 ☐ Inpa	<u>-</u>	ilent 3L DOA	<del>-</del>	Home 5 ☐ Resi					
n C	E E	ion	27. Manner of Death 1 ☒Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time lay Year) Injur	y W	uryat ork? ⊒Yes 2 □ No	28d. Describe	how injury occur	red			
Division of Vital Records,	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not determine	be an Blace of I	njury - At home, farm,			28f. Location (	Street and Numb	er or Rural Route Number,			
Ξ	of or A	Certification:	4 ☐ Homicide	building, e	etc. (Specify)			City or To	wn, State)				
	ospita hours unerel ty fille	cal C	29a. Certifier 1 Certifying P	hysicien: To the bes	t of my knowledge, de	ath occurred at the	time, date and place	e, and due to the	cause(s) and ma	nner as stated. and due to the cause(s)			
	To the Hospital or Attendii within 24 hours efter death. To the Funerel Director: A completely filled in by the fu	Medical	one)	and manners	stated.			uneu at the time,					
	5 vit	-	29b. Signature and time of certifier	Sundan	الدين	D533	nse number			d (Month, Day, Year)			
7	0	1					07		12-22-0	4			
7 1	2/10,	/	30. Name and address of person who				#2	02 Gaith	nersburg.	MD 20878			
1			R. Shyamsun	dar Kajon	MD. 10810	parnestor	wn Rd. "	-					

State Registrar

R. Shyamsundar 31. Date filed (Month, Day, Year) DEC 2 8 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42346 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Rosa Mae Colclough December 23, 2004 3:15 P.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adelphi
If Under 1 Year If Under 24 Hrs. Heartland Health Care Center Montgomery 8. Date of Birth (Month, Dey, Yeer) 2/20/28 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🛛 F 76 Augusta, Ga. Director 242-36-3957 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 850 52nd St., N.E. 20019 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 Ino Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Custodian U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virgil Saliard Sallie Coard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Departmant of Haalth ar important: If Itam 27 is any Injury or other trau Myrtle L. Burton/Sister 801 52nd St., N.E., Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/30/04 Landover, Md. Harmony Mem. Park 22. Name and Address of Facility
H.S. Washington & Sons Co. Inc.
4925 Burroughs Ave., N.E., Wash., D.C. 20019 21. Signature of Funeral Service Licensee Snau 23a. Part Inter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. **Physician** SEPSIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): SEVERE Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events VASCULAR DISTAGE Due to (or as a consequence of resulting in death) Last attanding p Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 THO 3 Probably 4 Unknown signed t 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? edical Certification: To Be Completed betes Mellitus 1 Tyes 21110 1 ☐ Yes 2 ☐ No cartificata 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Aftar 5 Pending investigation 1 Yes 2 No within 24 hours aftar daath.

To the Funeral Director: A complataly filled in by tha fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 112 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D0051122 04 Pe, Print) Esmarando Juanitez, M.D. WASHINGTON D-C 2 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) VARNUM ST. NE. 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 2 8 2004 Registrar

**DHMH 16 Rev 6/95** 

tha Marviano

Pagas 1 and 2 should be filad within 72 hours aftar daath with

or Attending Physician: The law raquires that the death cartificate be executed

ivision of Vital Records, P.O. Box 68760,

more, Maryland 21215-0020

State of Maryland / Department of Health and Mental Hygiers 42347 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER 21, 2004 **Physician** 7:45 A M COLLINS ROSE MARIE /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Oay, Year, JUNE 25, 1 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M XXF WASHINGTON DC Director 577-50-8550 1934 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 la marked othar than "natural", or Items 23a or 28a-f show traumatic evant, the Medical Exant ar must be notified at 1 ☐ Yes 2 ▼No Director OXON HILL MARYLAND PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 UNITED STATES 1103 WENTWORTH DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked othar than "r DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) 12 PROGRAM DIRECTOR DEFENSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be CHESTER ARTHUR HARDING DOROTHY L. COBERTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an itam 27 la LINDA M. BARNES - DAUGHTER 37485 HARROW HILLS COURT, MECHANICSVILLE, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DECEMBER 0 = 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Important: If any injury or once. TRINITY MEM. GARDENS 28, 2004 WALDORF, MARYLAND \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HUNTT FUNERAL HOME 21. Signature of Funeral Service Licensee M00053 Slohaun P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considuence of Examiner certificate be executed burial-transit and Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy certificate 20 No 1 ☐ Yes Division of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural after death. 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 THomicide within 24 hours a cal 29a, Certifier 1 🕱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) OUD LINE CONTER WALDONF, LID. ZEGOZ 12070 State 2 Registrar

			1 - For State Registrar	State of Marylan		artment of F rtificate of			iene • 2004	42348
Ī	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Pearl Loui	se Cookse	ey .			2. Date of Dear Month Decembe	er <sup>Day</sup> 19,200	3. Time of Death 04 9:20A M
	Examin		4a. Facility Name (If not institution, give single 1900 Lowell Road			4b. City, Town, a Pomf1		eath	4c. County of Dea	
ę	Funeral Director		5. Social Security Number 6. Sex 578-28-2691	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth Min. April	1 <sup>7</sup> 4 <sup>ar)</sup> 1927	rthplace (State & Foreign Guintry) Washington
	aryland		Usual Residence of Decedent   10a. State   10b. County   MD   Charle		y, Town or Lo Pomí					10d. Inside City Limits 1 ☐ Yes 2 No
	th the Ma or 28a-f	Irecto	10e. Street and Number		101111	10f. Zip Code		1	0g. Citizen of What C	
	ath wi	ralD	8900 Lowell Ro			206			USA	
5-0036	should be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23e or 28e-f ehow marked other than "natural", or items 21e or 28e-f ehow martic event, the Medical Examirer maral be notified at	by Funeral Director	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin' an, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh Specify:	
1215-0	within 72 ho noe. then "natur e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of Business	·
2	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)		HOME	illaket	18. Mother's	Name (First, Middle, I		=
Maryland 2121	should be I and Mental I s marked o umatic eve	To B	Charles Bryan H		10h Mailia	- A dida / C4	Bert		atherison	
	and 2 sl ealth an n 27 is r		Joseph Cooksey	husband	8900	) Lowell	l Rd.	r Rural Route Number Pomfret	, MD. 200	675
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		20a. Method of Disposition  1   → Burial 2 □ Cremation 3 □ Re  • 4 □ Donation 5 □ Other (Specify)		emetery, cren	sition (Name of natory or other place eph's Ce	em. 12		20c. Location - City of Pomfret	
Balti	permit. Pages Department of I Important: If It any injury or o		21. Signature of Funeral Service Licenses	Ehal MOC	945 22	Nagrenas P O 1	RTEECH	OLS FUNE 7, La Pla	RAL HOME	,P.A. 20646
*			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	eations that caused the death	Ο.	er the mode of dyir	ng, such as car	diac or respiratory arre		Approximate Interval Between Onset and Death
e es	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	-	ASTO	1-17.			
i.	á	ner	Sequentially list conditions, hany, leading to immediate cause. Enter Underlying	Due to (or as a nonseq	uanca of):					
ń	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	uence of);					-
68760	ficate be physicials to the but	edical	d.							
O. Box	The law requires that the death certificate be executed its has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	cc. If yes, outcome of pregna  1 Live birth 2 Feta  4 Pregnant at time of di  9 Unknown	Ideath 3□	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	olivery Day Year
ds, P.	uires that t signed by Id be deta	by	Part II. Other significant conditions cont	tributing to death but not resi	ulting in the ur	nderlying cause giv	en in Part I.		pacco use contribute t	o the cause of death?
Records,	: The law require cate has been sig page 2 should to	Completed						24a. Was ar autops perform	y prior to ned? death?	utopsy findings available completion of cause of
ā	ilcian: Th certificate rector, pag	Be Co	25. Was case referred to medical				26. Place of	1 ☐ Yes 2 Death (Check only only	<del></del>	s 2 No
of Vital	Physician: this certifica ral director, p	၉	1 165		ER/Outpatien		T I HUI SIII	ig Høme 5⊟Reside		ecify)
00	ding After fune	tlon:	27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending Physician: To the Funeral Director: After this certifica To the Funeral Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number or R n, State)	ural Route Number,
	Mospita 24 hours e Funera letely fille	Medical C	29a. Certifier Certifying Physic (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tire estigation, in my o	ne, date and pl pinion, death o	ace, and due to the ca	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier	- M - DO		29c. Licens		29	9d. Date signed (Mon	th, Day, Year)
C			30 Name and address of access the	11 (all	~~	D 2	153	, , , 2	19/20	104
1	B5		30. Name and address of person who con	17x	03	Lot	(0)	e Mod	206	46
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 2 2	32. Registrar's Signa		Souls?				`-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 23a-b,pt.11,25 per me 6843 5-12-05 tas

Certificate of Death

Reg. No. 42349 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 22 **Physician** JAMES L. CAREY 2004 11:28 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAVRE DE GRACE HARFORD HARFORD MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F 51 Yrs. 218-56-0362 May 25, Virginia Director 1953 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 23a or 28e-f show 1 XYes 2 ☐ No Director Maryland Harford Havre de Grace 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21078 1210 Revolution Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Home Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental H Willard C. Carey, Sr. Fannie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Carey / wife 1210 Revolution Street, Havre de Grace, MD 21078 Department of Heelt Important: if item 2: eny injury or other i once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Berkley Cemetery 12/27/04 Darlington, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Signature of Funeral Service Licensee

Lisa Scott Funeral Home, P.A.

552 Lewis Street, Havre de Grace, MD 2107

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death MD 21078 Immediate Cause (Final disease or condition resulting in death) sepsis syndrome Physician /Medical Due to (or as a consequence of); Examiner preumona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CENTRICITION APPROVED BY MEDICAL EXAMINES burial-transit Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failure from thepatitis ( 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Quadrapliquadue to cervical abscess 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 XYes 2 10 26. Place of Death (Check only one) Hospital: 2☐ER/Outpatient 3☐DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the Hos within 24 ho To the Func (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 12/23/04 200048050 stitte Abedeen no 2100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 155. Parke Prashant Shutle ma 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 8 2004 Court )

DHMH 17 Rev 1/2001

Registrar

10-CE-

		-	For State Registrar	State o	f Maryland		artment of i		ind Men		ene 20	) 4	423	50
	ysicia		1. Decedent's Name (First, Middle, Wendell A. Culbe						_ N	Date of Death Month Lember		<sup>'ear</sup>	3. Time of De 15:35	
1	ledic amin		4a. Fecility Name (If not institution,		mber)		4b. City, Town,	or Location o		- CMOCC	4c. County of	-	13.33	1
. 65			Calvert Manor He	althcare	Center		Risino				Ceci	l		
Fund				3. Sex 1∭2 M 2□F	7. Age (In yrs. la		If Under 1 Year Months Days		Min. (/	ate of Birth Month, Day, Y	ear)	O. Birthpla Countr		
Direc	ctor	-	005-28-8694  Usual Residence of Decedent	~	8	33 Yrs.			Nov	20,	1921		Canad	<u>a</u>
yland	=		10a. State 10b. County		10c. City,	, Town or Lo	cation					10	d. Inside City L	
death with the Maryland ms 23e or 28e-f ahow	diffee	ctor	MD Cecil		Risa	ing Su							1 Tes 2	No No
with th	De no	Directo	10e. Street and Number				10f. Zip Code			10g	. Citizen of Wh	at Countr	y?	
eath v	must	Funerai	779 Wilson Road  11. Marital Status	12. Was Dec	edent Ever in U.S	S. 13. 1	21911 Was Decedent of		ain? (Specify	Yes or No-	USA 14. Race -	America	n Indian.	
after d	diner		1 ☐ Never Married 2 ☐ Marrie	Armed Fo d 1 ☐ <b>Y</b> es	rces? 2 🗌 No		f Yes, specify Cul	ban, Mexican	, Puèrto Ricar	n, etc.)		White, et	tc.	
3-UU30 72 hours after	Era	d b	3 ₩idowed 4 □ Divorced	If Yes, Giv Year or D	ates: WW 11	[	1 □ Yes 2 □XNo	Specify:			Specify:	Whit	ie .	
127 n	edica	ete	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retin	e durina most	of working	16	b. Kind of Busin	ness/Indu	ıstry	
d Z IZ I	De M	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		orer	50)		ļ	Equest	nian	,	
and be filed antal Hyg	vent,	O	17. Father's Name (First, Middle, L.	ast)				18. Mother	r's Name (Fir	st, Middle, Ma	iden Sumame)	· c· coort	-	
IOTE, INGRYIGHO ZIZIS-UUSO ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f ahow	atic	ToB	William Earle Cu							.сса Ве				
2 sho	raum	1	19a. Informant's Name/Relationshi				ng Address (Stree				, , , , ,		2ode)	
C, I	thert		Jo Ann Frock/dau 20a. Method of Disposition	ignier	20b. Pla	ace of Dispo	Wilson sition (Name of	1	Rasing	-	MD 219 c. Location - Cir		vn. State	
Pages Pent of net: If it	y or o		1 XBurial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Spe		State		natory or other pla metery		12-29-2		Oxford	•		
Daltimor permit. Pages Department of Importent: If it	any injur once.	Ì	21. Signature of Funeral Service Li		دا		Name and Addr 11 S. Qu							
# # O E	a o		Luchard &	7.	ogie	Do not on	11 S. Qu	ieen St	reet,	Rising	Sun, M		21911 Approximate	
25	*. \$5.		23a. Part . Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	nly one cause on e	ach line.	,	/ - /		cardiac or res	piratory arres	ι,	1	Interval Betwee Onset and Dea	
Pnysic /Med			disease or condition resulting in death)	a. Due to	(or as a consequ	ence of):	end ste	ge		-		_		
Exami	ner		Sequentially list conditions,	b										
D.	is.	iner	if any, leading to immediate	Due to	(or as a consequ	ence of):								
<b>bu</b> , be executed	I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ	ence of):						_		
8 / bU, cate be executed ohysicien and	buria	calE				,								
ortificate ding phys	as the	edi		U			-							
cords, F.O. BOX or requires that the death certific been signed by the attending p	esn Je	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregnan		Ectopic pregnan	су			23d. Date of	,	y Day Yea	3,5
J. BO ne death the atten	hed fo	/sici	1 Pes 2 No 9 Unknown	4□Pregr 9□Unkn	nant at time of de own	ath 5	Other (specify)				Month		/ay 16a	
Ords, P.O requires that the een signed by th	detac		Part II. Other significant condition	s contributing to d	eath but not resul	Iting in the u	nderlying cause g	iven in Part I.		23e. Did toba	cco use contribu	ute to the	cause of deat	th?
ecords, law requires t as been signe	ed be	d by								1 🗌 Yes	2/2/No 3	☐ Probaí	bly 4 □Unk	nown
ecor law req as beer	should	iete								24a. Was an	24b. We	re autop:	sy findings ava	ailable
VITAL MEC sician: The law s certificate has t	page 5	Completed								autopsy performe 1 ☐ Yes 2 ☑	d2 dea	or to comp ath? Yes 2	pletion of caus 2□ No	se of
VICAL K Ician: The Certificate h	ctor. p	BeC	25. Was case referred to medical examiner?					26. Place	of Death (Ch		3.110			
Of VITA Physician: rthis certific	al dire	2	1 ☐ Yes 2 ☑ No	-			it 3L DOA				e 6 Other			
Jn OT ding Phys	funera	ion:	27. Manner of Death  1. ■ Natural 5 □ Pending		th, Day Year)	28b. Time o Injury	W	uryat ork? ⊒Yes 2 □ N		Describe how	injury occurred			
DIVISION  or Attending after death.  Director: Afte	y the	ertification:	2 Accident investigation of Could not determine	ot be 28e. Place	of Injury - At hor	me, farm, str	eet, factory, office		28f. L	ocation (Stree	et and Number	or Rural	Route Number	r.
el or /	d in b	Certi	4 Homicide	build	ing, etc. (Specify)	)	•			City or Town, S	State)			
LIVISION  To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After	completely filled in by the funeral director,	edical (		Physician: To the examiner: On the b										
o the	omple	Me	29b. Signature and title of certifier	and man	nor states.	<del></del>	29c. Licer	nse number		29d	. Date signed (/	Month, D.	ay, Year)	
- > -	0		1 Juni	20,	MO		Do	6076	68	/	12/281	104		
1	)		30. Name and address of person w	who completed cause	se of death (Item	23a) (Type,	Print) E. Mai	in St.	Ris	ing Sa	un, Mr	> 2	1911	
	Sta	te	31. Date filed (Month, Day, Year)	32. F	Registrar's Signat	ure		., .,	, , ,	1	/ / / /		111	
Re	gistr		DEC 2 8 2004	Marce	11 16	Carle	,							

04-08471 ALLEN DURST

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible. unpend item# 23a, 27, 28a-f, per ME, C839, 1731705 Ti 42352 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Year **Physician** ALLEN  $W_{-}$ 31, 2004 10:06 A<sup>M</sup> DURST DECEMBER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 18449 LOST KNIFE CIRCLE # 102 GAITHERSBURG MONTGOMERY CO 8. Date of Birth (Month, Day, Year) Dec. 30, 1976 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax **Funeral** Penn. Months Days Hours 1⊠M 2□F 28 Director 220-06-1610 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show traumatic evant, the Medical Examiner must be nutified at 1 ☐ Yes 2 No Gaithersburg MD Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 18449 Lost Knife Circle, #102 20879 238 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: 2 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 h and Mental Hygiene. 7 Is markad othar than "na College (1-4or 5+) Elementary/Secondary (0-12) 12th Cable Installer Comcast 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Brown Garland O. Durst ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20853 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health ar
Important: If Itam 27 Is
any injury or other trau 14112 Chesterfield Rd., Rockville, MD (Mother) Hilda M. Sieling 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-6-05 Metro Funeral Srv Alexandria, VA 4 □ Degation 5 □ Other (Specify) Funeral Service Vice se 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Narcotic and Cocaine Use /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ō Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the ģ 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Tes 2 No 24a. Was an page 2 autopsy performed? 1 Yes 2 No Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1X Yes 2 □ No ည SCENE 28a. Date of Injury Frigorith, Day 12/31/04 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Fndnjury 9:35 A M 5 Pending 1 Natural after death. 1 ☐ Yes 2 🙀 No investigation 2 Accident unk 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 18449 Lost Knife Circle Gaithersburg, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide found at home a Funaral 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

MANYSTUDS 31. Date filed (Month, Day, Year) **JAN 05** 2005

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201 KOREL Registrar's Signature marke

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OCME

JANUARY 1, 2005

DHMH 17 Rev 1/2001

Registrar

		. For	State of Maryland	/ Depa	rtment of H	lealth and l	•	9	1.2351
		State Registrar		Cer	tificate of I	Death		g. No.	42004
Physicia /Medica		1. Decedent's Name (First, Middle, Last, Nellie, Dun	nock				2. Date of Death Month	Day Ye 21 200	y 1120 AM
Examine	r	4a. Facility Name (If not institution, give			0 1	Location of Deat	1	4c. County of D	Pe <sup>l</sup> ath
Funeral		5. Social Security Number 6. Sec.	x 7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9.	Birthplace (State or Foreign Country)
Director		214-18-4033 1D Usual Residence of Decedent	M 2007F 81	Yrs.	Months Days	Hours Min.	Sept. 11,	1923 M	Nary land
11215-0036 MCC. within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 ehow the Madical Evantinar must be natified at	ō	10a. State 10b. County	10c. City, T			_			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
28a-	rect	MD Dorch  10e. Street and Number	ester.	.an	1 bridge	2	10	ng. Citizen of What	
23a ou	Funeral Director	801-Trumar	Street		21	613		USA	
Ser dea	nue	11. Marital Status	<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>	13. V	Vas Decedent of H Yes, specify Cuba		pecify Yes or No- co Rican, etc.)		merican Indian, /hite, etc.
5-0036 %	DY F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>☑</b> No If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify:	ack
5-003	ted	15. Decedent's Edu (Specify only highest grad	cation 1	6a. Deced	ent's Usual Occupa	ation	tion 1	6b. Kind of Busine	a.C.K ess/Industry
Ind 21215 be filed within 73 tal Hygiene. of other than "in evant, Its Madi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o OO NOT use retired			2 , 1	.0
d 21 filed wi Hygien other th	2	17. Father's Name (First, Middle, Last)		DOM	estic	18. Mother's Nar	ne (First, Middle, M		. Residence
	lo Be	Joseph	Chester			EMN		nish	
Maryland 2121. d 2 should be filed within th and Mental Hygiene. 77 Is marked other than " traumatic event, the Max		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number,		e, Zip Code) 2/2/7
			Ennels	717.	Druid f	ark La			More, MD.
0 % = 5		20a. Method of Displosition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	etery, cren	sition (Name of natory or other plac	e) 12		Oc. Location - City	
Baltim Dermit. Pag Department Important: any injury o	ŀ	<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>		one	CeMete	ss of acility.	2 1/07/	ladisou	n, Maryland
Deg min per many many many many many many many many		Danelle (	. Henry	H	INVIASH	neral 1	- Combri	dae Mi	D. 21613
		23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the death. I	Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Interval Between
Pnysician		Immediate Cause (Final disease or condition	Severe a	corte	· Stewi	25 65			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequen						
	آ و	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):					
xecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Final Inderlying Cause (Disease or injury that initiated events	2.						
	ద	resulting in death) Last	Due to (or as a consequen-	ce of):					
rte nys	dical		d						
I Records, P.O. Box 68. The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Completed by Physician/Med	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy		Ectopic pregnancy			23d. Date of	delivery
by the attrached for	SICIS	in the past 12 months? 1 □ Yes → No 9 □ Unknown	4☐Pregnant at time of death		Other (specify)		<del></del>	Month	Day Year
P.O. that the ed by th detache	5	Part II. Other significant conditions con	ntributing to death but not resultin	a in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute	a to the cause of death?
Records, the law requires t e has been signe age 2 should be o	D D	Afrial Ebrillation						Com	Probably 4 □Unknown
aw requ	plete				,	7	24a. Was an		autopsy findings available
The law	E						autopsy perform		
Vital F sician: Th certificate irector, pag	e C	25. Was case referred to medical examiner?	Innaital: 1		0.1		th (Check only one	)	
thy ships	0	1 Yes 2 No		Outpatient	3 □ DOA Othe	4 🗀 Nursing n	ome 5 Resider		(pecify)
ion ording lath.	I O	1 Natural 5 Pending investigation	28a. Nate of Injury (Month, Day Year)	Injury	Work	(? Yes 2⊟No	200.000.00	,ary occarios	
Division of or Attending Phy after death. Diractor: After this I in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
Hospital or 4 hours afte Funaral Dirtied in Itely filled in It									
Division  To the Hospital or Attent within 24 hours after dealt To tha Funaral Diractor: completely filled in by the	edical	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time estigation, in my op	ne, date and place pinion, death occu	and due to the cau red at the time, dat	use(s) and manner te and place, and c	as stated. due to the cause(s)
To the within 2 To tha complet	Z E	29b. Signature and title of certifier	1		29c. License	number	29	d. Date signed (Mo	onth, Day, Year)
		What I	1		1300	80/59-10	13	PSP- he	21 2004
		30. Name and address of person who co	ompleted cause of death (Item 23	a) (Type, F	Print) Ndidi	Bonique	Foy Fein	berg, M.	D.
		JOUILACH RELIGION B	IVIS PORTEROR	Bo.	thrust.	MIS 212	35		
State Registra	_	31. Date filed (Month DEC 2 3	2004 32. Resistrar's Signature	K D	book				

			For State Registrar	State	of Maryla		artmen rtificat			and M	-	giene Reg. No:	1001	1, 2	255
	Physici	an	Decedent's Name (First, Middle	Last)	D	та:	17				2. Date of De Month Decemb		Year	3. Tin	ne of Death
	/Medic	al	Alma 4a. Facility Name (If not institution,	aive street and	B.	E.	11wang		Location of	of Death	Decemb		County of De		35AM <sup>™</sup>
	Examir	er	Southern Mary	-			40. Oily,	Clir		n Doam		1	ince G		S
	Funeral Director		5. Social Security Number 406-24-3635	6. Sex 1 □ M <b>X</b> (X)F	7. Age (In yr 79	rs. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	Min	8. Date of Birt (Month, Da lay 21,	h y, Year) 1925	9. B Ke	irthplace (St Country) ntucky	ate or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or L	ocation							10d. Insid	de City Limits
	Mary a-f sho	tor	Maryland Prince	George's	,		Clir	nton						1 🗆	Yes XX No
	h with the	Dire	10e. Street and Number 5915 Alan Drive				10f. Zip		735			10g. Citi	zen of What (	S.A.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show fre Madical Exaciliter cust be notified at	by Funerai	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed 1   Ye If Yes,	ecedent Ever in Forces? s 2 (X) No Give Dates:	U.S. 13.	Was Deced If Yes, spec	77	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	1	14. Race - Am Black, Wh Specify: W	ite, etc.	ın,
5-0	thin 72 ho e. an "natur Medical	Completed	15. Decedent (Specify only highes	s Education grade complete	d)	16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa	ition Juring mosi	t of workin	ıg	16b. Kir	nd of Busines	s/Industry	
121	filed within Hygiene. ther than int, the Ma	dwo	Elementary/Secondary (0-12)	College	(1-4or 5+)		ninist					U.S	. Gove	rnment	
Maryland 2	be d al	To Be C	17. Father's Name (First, Middle, I Henry C. Bar						18. Mothe		(First, Middle,		Sumame) tter		
ary	12 should th and Mer 7 Is marke treumatic	-	19a. Informant's Name/Relationsh				_				Route Numbe				
	s 1 and 2 f Health Item 27		Edward E. Ellwa	nger (Hu					-		on, Mar				
Baltimore,	of of		20a. Method of Disposition  1 Daurial 2 Cremation			. Place of Disp cemetery, cre					<b>2</b> 7, 20				
Ħ	当年記言	l	* 4 ☐ Donation 5 ☐ Other (Sp.  21. Signature of Funeral Service I		Ma	aryland 2					e Fune		ltenha		утапи
	Friysician /Medical	8 1	21. Signature of Funeral Service Licenses  22. Name and Address of Facility  100/53  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.								_Ferry	Roa rest,		ton, M Approx Interva	
8760,	Examiner	Icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due c. Due d.	to (or as a cons		Pac	um	olm	<u>a</u>				72,	h
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Liv	outcome of preg e birth 2 ☐ Fe egnant at time o known	etal death 3	⊒Ectopic pi ⊒ Other (sp					2	23d. Date of d Month	elivery Day	Year
Δ.	uires that n signed b ild be deta	by	Part II. Other significant condition	ns contributing to	death but not r	esulting in the (	underlying o	ause give	en in Part I.		23e. Did to		se contribute □ No 3 🗆 F		of death?
I Records,		Completed											24b. Were a prior to death?	completion	ngs available of cause of
Vital	Physician: Th this certificate ral director, pac	Be	25. Was case referred to medical examiner?	Hospital:	/		-	Othe	. 64		(Check only o				
of	ng Phys ter this neral di	tion: To	1 Yes 2 No  27. Many er of Death 1 Natural 5 Pendin 2 Accident investig	28a. Da	☑Inpatient 2 te of Injury onth, Day Year)	28b. Time of Injury		28c. injury Work	4 LINU	2	ne 5 🗀 Resid 8d. Describe h			ecify)	
Division	el or Attendl s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Pla	ce of Injury - Al Ilding, etc. (Spe	t home, farm, st ecify)	treet, factory	y, office		2	8f. Location (S City or Tox			Rural Route	Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		Physician: To Examiner: On the and m											Ise(s)
)	To th withir To th	Me	29b. Signature and Ittle of certifier	21	12			License	number -45	35			e signed (Mor	1	ar)
4	RIC		30. Kame and address of person Laxmi N. Berwa	. M.D.	7700 010	1 Branc	, Print) h Aver	nue #			nton, M	D 20	735		
	Sta Regist		31. Date filed (Month, Day, Year)  DEC 2.2	2004	. Egistrar's Sig	gnature A	barle	,							

			For State Registrar		Sta	te of N	Marylan		artmen				lental Hy	Reg. No	200	14	42	356
	Physicia	an	Decedent's Name	(First, Middle,						_			2. Date of D Month	Dav	200	(ear	3. Time d	#béath U
	/Medic	al .	Bertha		С			F	ranke		. I - cation		ecembe		200 County of		7:34	P. M
	Examin	er	4a. Facility Name (If Suburba:			иа питов	or)			hesd	Location o	or Death			tgon			
	Funeral		5. Social Security Nu		6. Sex		Age (In yrs.	last birthday,	If Under	1 Year	If Under		8. Date of B (Month, D			9. Birthpl	ace (State	or Foreign
	Director		283-14-94	91	1 □ M 2	X F	93	Yrs.	Months	Days	Hours	Min.	June 2	22, 19	11	Penr	isylva	ania
	and w		Usual Residence of	Decedent 10b. County			10c. Cit	y, Town or L	ocation							10	d. Inside C	City Limits
	Maryla f sho	o	Maryland	Montgo	omerv			evy Ch									1 ¥Yes	2 □ No
	r 28e-	Director	10e. Street and Num						10f. Zip	Code				10g. Citiz	en of Wh	at Count	ry?	
	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show initial Examination must be multified at	aiD	4604 Lang	drum La	ane				20	815				Unit	ed S	State	es	
	r dea	Funeral	11. Marital Status		Am	ned Force		.S. 13.	Was Deced	dent of Hi	ispanic Ori in, Mexicar	igin? (Span, Puerto	ecity Yes or N Rican, etc.)	10- 1	4. Race - Black,	America White, e		
36	s afte	by Ft	1 ☐ Never Marrie 3 ☑ Widowed		If Y	]Yes 2[ 'es, Give arorDate:			1 ☐ Yes	2 🔀 No	Specify:				Specify:	W	hite	
21215-0036	thou	edt	**	15. Decedent		ar or Date.		16a. Dece	dent's Usua	al Occupa	ation			16b. Kir	d of Busi			
215	_ 38	plet	(Speci Elementary/Secon	ify only highes		oleted) llege (1-4d	or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	during mos f)	st of work	ng					
7		Completed				1		Hon	nemake	r					vn Ho			
nd	be filed ntal Hygie od other	0	17. Father's Name (		.ast)	0 - 1							(First, Middl	e, Maiden i		goli		
Maryland	should be nd Mental marked c	2	A .  19a. Informant's Na	Harry	in (Type Pri	Cohe	en	19h Mail	ing Address	(Street a		Hanna	111 al Route Num	ber City or				
Ma	id 2 s Ith an 27 is r traur		Hannah F.		daug	_			-				evy Cha			20815	_	
ē,	t Hear f Hear ltem		20a. Method of Disp	osition			1 7	Place of Disp cemetery, cre	osition (Nan	ne of			Date	1	ation - C	ity or Tov	vn, State	
Ë	Page Fire of o		1 ☑ Burial 2 ☐ `4 ☐ Donation			al from Sta	.10	-				12/24	/2004	Colu	ımbus	, Oh	io	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked to any injury or other traumatic events.		21. Signature of Fu	neral Service L	icensee	ott	imu	es Î	<sup>2. Name an</sup> Oanzan .170 R	d Addres	ss of Facility Gold Gille	berg Pik	Memor:	ial Ch kville	napel	Ls, ]	[nc. )852	
Н			23a. Part1. Enter the shock, or hear	ne disease, or	complications	s that caus	sed the deat	th. Do not er	iter the mod	le of dyin	g, such as	cardiac	or respiratory	arrest,			Approxima Interval Be	tween
	Physician	0.0	Immediate Cause ( disease or condition	Final	a	7	morid	,									Onset and	Death
	/Medical Examiner		resulting in death)		(" [		as a cons			1-		1	1/2					
	LXammer	ē	Securitizity list our	nditions.	b. —	They	OSC E	Monce of):	- Car	110	Vas	culd	r dis	ease	,	-		
	ted nsit	nlne	if any, leading to im cause. Enter Under Cause (Disease or that initiated events	rlying <		10) 01 686	<b>43</b> 4 00(1300	adrice or).	•									
<b>.</b>	execu n and ial-tra	Examin	that initiated events resulting in death) L	ast	c.	Oue to (or	as a conseq	quence of):								===		
68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai			d. ==													
99	rtifica ng ph s as th	Med	IF FEMALE:															
Вох	Jeath certifica attending ph for use as t	Physician/Med	23b. Was decedent in the past 12		10	Live birth	me of pregna 2 ☐ Feta	al death 3	□Ectopic p		,			2	3d. Date Monti		y Day	Year
0	the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No		_Pregnant ☐ Unknown	t at time of c	death 5	Other (sp	эесіту)								
<u>α</u>	es that the de igned by the be detached		Part II. Other signifi	icant condition	ns contributi	ng to deat	h but not res	sulting in the	underlying o	ause giv	en in Part	1.	23e. Did	tobacco u	se contrib	ute to the	e cause of	death?
Records,	quires n sign	d by	Rib	tract	ures								1 🗆	Yes 2	No 3	☐ Proba	ably 4	Unknown
000	s been s	olete	Arm.	Pract	ure								24a. Wa	is an	24b. We	ere autop	sy findings	available
æ	The law cate has page 2 s	Completed	1111											formed?	de	ath?	2 0	cause of
Vital		Be C	25. Was case referr	red to medical							26. Place	e of Deat	Check only				X	
of V	S S	은	1 Yes 2		Hospita	1 U Inp		ER/Outpatie			4 🗀 🕅	ursing Ho	me 5 Re				)	
NO.	ding Phy h. After thi funeral o	ion:	27. Manner of Death	5 🗌 Pendin	9 1	Month,	Day Year)	28b. Time Injury		28c. Injur Wor	yat k? Yes 2. ☑	/No	28d. Describe	now injury	occurred	a		
Division	or Attending utter death. Director: After in by the fune	cat	2 XAccident 3 Suicide	investig 6 🗌 Could r	not be	Place of	Injury - At h	UNKN ome, farm, s			103 213	1.00	28f. Location	(Street and	l Number	or Rural	Route Nur	n <i>ber</i> ,
Ρį	after after I Direct	Certification:	4 🗌 Homicide	determ	nied 🔿	building,	etc. (Speci	fy) N .	1 /	1 .	ing		1 2 is or T	Seven	Lock	SR	oad	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only		g Physician: Examiner: O	: To the be	st of my kno	owledge, dea					and due to th					s)
	To the within To the complex	Me	29b. Signature and	1 1	Tona	sko	Ma	y, M	19-	Do	e number	S		_	10	1 1	0 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	
	V		30 Name and addr		who complete	ed cause of	V	m 23a) (Type	Print)	p.	te	G-1	100, K	octi	ille	MI	7 20	852
		ate	31. Date filed (Mon	th, Day, Year)	2004	32. Reg	istrar's Sign	ature <b>4</b>	So	uks	1	- /	-/ "	-/(-	7			,
	Regist	rar	DE	C 22	2004	1			1									

			1 - For State Registrar	State o	f Marylar		artmen <i>rtificat</i>					Reg. No	200	4 42	35
	Physici /Medic		Decedent's Name (First, Middle,  LILLIAN	FA	AGLES		T				2. Date of De Month DECEMBI	ER 1	7, 2004	12:40	**
	Examin		4a. Facility Name (If not institution, HOLY CROSS HOSPI	-	mber)				Location of PRING				ONTGOME		
	Funeral		-	S. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under Hours		8. Date of Bir (Month, Da	th	9 Bir	rthplace (State ( country)	or Foreign
	Director		578-10-3671 Usual Residence of Decedent	1 □ M 2 📉 F		87 Yrs.	IVIOITALIS	Days	Tiodis	IVIII I.	JAN. 31	i, 1	917 PEN	NSYLVAN	IA
	ryland how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside C	ity Limits
	Ba-f s	Funeral Director	MARYLAND MONTGO	MERY	ROC	KVILLE					· · · · · · · · · · · · · · · · · · ·				2 <b>X</b> No
	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show The Medical Evaniaet must be notitied at	Dire	10e. Street and Number	A 1717NIII7			10f. Zip		853				tizen of What C	ountry?	
		nera	4615 WISSAHICAN .  11. Marital Status	12. Was Dece	edent Ever in U	J.S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		S · A ·		
36	s after	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	Armed Fo d 1 ☐ Yes If Yes, Giv Year or D	/8		1 ☐ Yes		Specify:		riloun, sto.)		Black, Whi	HITE	
9	2 hour		15. Decedent's	Education	ates.	16a. Dece	dent's Usua	al Occupa	ation	4 - 6 - 4		16b. F	(ind of Business		
21215-0036	_ ×	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	1-4or 5+)		kind of wo	se retired	) )	t ot work	ing	OT 01			
d 2	be filed withir trail Hygiene. Ind other than event, the Manager trails.		12 17. Father's Name (First, Middle, L	ast)		SALES	WOMAN		18. Mothe	er's Name	e (First, Middle		THING  Sumame)		
Maryland	w m _ >	To Be	PHILIP C. MY	ERSON				]	ROSE		I	EVI	NSON		
Man	12 sho h and l		19a. Informant's Name/Relationshi	р (Турө, Print)		1	-						or Town, State,		
	es 1 and 2 should b of Health and Ments fitem 27 Is marked r other traumatic e		ALAN FAGLES/SON  20a. Method of Disposition		20b.	Place of Dispo	sition (Nar	ne of			$\operatorname{OCKVILL}_{Date}$		MD 2085; ocation - City or		
E O	nit. Pages partment of lorrant: If its		1 X Burial 2 ☐ Cremation : 1 4 ☐ Donation 5 ☐ Other (Spe		State	cemetery, crei G DAVII	-	•	,	2/19	/2004	FAL:	LS CHUR	CH. VIR	GINTA
Baltimore,	permit. Pages Department of Important: If it any injuger o		21. Signature of Funeral Service L	Ludew	ia	E1 10	Name an DWARD 191 RO	SAGI OCKV	s of Facilit EL FU ILLE	NERA PIKE	L DIREC	TION TLL	N, INC. E, MD 20		
Vital Records, P.O. Box 68760,	death certificate be executed  Wedical  Water and the burial-transit  d for use as the burial-transit		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that only one cause on e	eased the dea ach line.	th. Do not en	ter the mod	e of dying	g, such as	cardiac d	or respiratory a	rrest,		Approximat Interval Bet Onset and	tween
			Immediate Cause (Final disease or condition resulting in death)	a. SEPSI		THEROO Off:								24 HOU	
		Due to (or as a consequence of): PERITONITIS													
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
		Examine	that initiated events c.  resulting in death) Last  Due to (or as a consequence of):												
	ate be shysicia the bu	edical	d												
	eath certific attending p for use as f	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregn	ancy							23d. Date of de	livery	
	the che	Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown		ointh 2 ∏ Feta nant at time of c own		∃Ectopic pr ∃Other <i>(sp</i>						Month		Year
	sign sign	by	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying c	ause give	on in Part I.			obacco Yes 2	use contribute to	o the cause of c	
	0 - 0	Completed								<del></del>	24a. Was autor perfo 1 Yes		prior to death?	utopsy findings completion of c	available ause of
/ita	Physician: The this certificate ral director, pag	BeC	25. Was case referred to medical examiner?	(In-exist)				0.5			(Check only o	one)			
of	Phys	1: To									ne 5 Residence 6 Other (Specify)  Bd. Describe how injury occurred				
Division	Attending Pr r death. ector; After th by the funeral	ation	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Pending M 1 Yes 2 No							300.00					
	Dire	Certification;	3 Suicide 6 Could no determin	ed 286. Place	of Injury - At h ng, etc. (Speci	ome, farm, sti	reet, factory	r, office			28f. Location (3 City or Tox	Street ar vn, State	nd Number or Ri a)	ural Route Num	ıber,
	24 hos Fur etely	edical (	29a. Certifier 1 Certifying (Check only one)  1 Certifying  1 Medical E	Physician: To the xaminer: On the band man	best of my knoasis of examination stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim , in my op	e, date an	d place, a	and due to the ed at the time,	cause(s date an	) and manner as d place, and due	s stated. e to the cause(s	;)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	10 0	20:1		290	. License	number			29d. Da	te signed (Mont	th, Day, Year)	
•	15		30. Name and address of person w	L I LCL	Ull se of death (lea	D 23al /Time	~	0056	5153			DECI	EMBER 17	7, 2004	
	-		KRISTIE NOWAK, M					SILV	ER S	PRIN	G, MARY	LANI	20910		
*	Sta Registr	te	31. Date filed (Month, Day, Year)  DEC 22	32. P	egistrar's Sign	ature	Spo								

328	/		1- For Amend Item 1&Unpend Item 23a&27	partment of Health and Mental H Der the 6840 2-15-05 tas ertificate of Death	ygiene			
	a		1. Decedent's Name (First, Middle, Last) Thomas Friend	2. Date of 8 Month	Death Day Year 3. Time of Death			
	Physici /Medic		Thomas Willard Friend		_ 1			
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
			Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Hagerstown  J If Under 1 Year   If Under 24 Hrs.   8. Date of 8	Washington			
	Funeral Director		218-48-7681 15tM 2 F 48 Yrs.		Dav. Year) Country)			
			Usual Residence of Decedent	pune 2	o, 1950 Haryrand			
	death with the Maryland ms 23e or 28e-f show	_	10a. State 10b. County 10c. City, Town or	_ocation	10d. Inside City Limits			
	the Ma 28e-f	Director	MD Garrett	0akland	1 ☐ Yes 2 ☑ No			
	with ti		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?			
	ns 23e	Funeral	159 Old Crellin Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21550  Was Decedent of Hispanic Origin? (Specify Yes or I	USA No- 14. Race - American Indian,			
	or Items	Fun	1 XNever Married 2 Married 1 Yes 2 No	I. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.			
21215-0036	72 hours after natural', or Ite	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specity: White			
5-(	72 hours "natural",	Completed	(Specify only highest and ecompleted) (Given	edent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry			
121	within ene. than	ф	Elementary/Secondary (0-12) College (1-4or 5+)	Laborer	Wood Products			
d 2	filed Hygid other ent,		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd				
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Exame is a marked to confile of a confile of the traumatic event.	To Be	Donald Ray Friend	Freda Mar				
				iling Address <i>(Street and Number or Rural Route Num</i> 59 Old Crellin Road, Oakl				
Je,			20a. Method of Disposition 20b. Place of Dis	position (Name of Date ematory or other place)	20c. Location - City or Town, State			
Ë	nit. Page partment i ortant: if		1 ⊠Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Blooming	g Rose Cem. 12/29/04	Friendsville, Md			
Baltimore,	permit. Pages Department of I Important: if ite any injury or or once.				2 S. Second St. akland, Md. 21550			
г	Physician /Medical Examiner price pr		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory	Interval Between			
			Immediate Cause (Final disease or condition a. Arteriosclerotic	cardiovascular disease	Onset and Death			
			resulting in death)  Due to (or as a consequence of):					
		- G	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
o,		Еха	resulting in death) Last Due to (or as a consequence of):					
8760,	tte nys	dicai						
9	certifica nding pt use as ti		IF FEMALE:					
Вох	death certifics e attending pt ed for use as ti	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d. Date of delivery  Month Day Year				
o.	0 0 0	ysic	1  Yes 2 No 4 Pregnant at time of death 5					
۵.	v requires been sign should be	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	d tobacco use contribute to the cause of death?			
of Vital Records,				10	1 Tyes 2 No 3 Probably 4 Unknown			
00		ompieted		24a. We				
R	9 2 9	HO.		pei Nes	normed? death?			
/ita	Physician: this certific ral director,	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only				
of \		2	1 X Yes 2 No Hospital: 1 □ Inpatient 1 ER/Outpati					
		ion	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Date of Injury (Month, Day Year)		e how injury occurred			
Division	f or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s		(Street and Number or Rural Route Number,			
ă	D it te	Certification:	4 Homicide determined building, etc. (Specify)	City or I	own, State)			
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical C	29a. Certifier  (Check only (C	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)			
	ro the	Me	29b. Stanature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
	> - 0		1X ( solo AMD)	O.C.M.E.	December 24, 2004			
	2		30. Name and address of person who completed cause of death (Item 23a) (Type	n. Print) 111 Penn Street, Balti				
	Sta	te	31. Date filed (Month, Day, Year) 32. Register's Signature		more, 21201			
.*	Registi		DEC 2 9 2004	A COURT				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** U11/1000 Gerald 20 2004 6:20 PM December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Salisbury
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Wicomico Wicomico Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F 219-14-3049 Yrs. 192 Director Sept. 10 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Salisbury 1 Yes 2 No Director Wicomico MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 928G, U.S.A ave 21801 Funerai 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 Widowed 4 Divorced BIACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'ne eny injury or other traumatic event, the Medica 2006. Elementary/Secondary (0-12) College (1-4or 5+) 8th Grales Truck VeR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 2 Un Known Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) WI Virgina B. Gerala -20f. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donatten 5 Other (Specify) MD Veterns Centery 12/27/04
22. Name and Address 1 Facility Sonnie Sn 5mits Funcal 21. Signature of Juneral Service Licensee Humo 7 WISAbolk St - Salsbury 21801 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and Due to (or as a consequence of) the attending physician a hed for use as the burial-Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ þe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed this certificate 1 Yes 2 No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Kortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-0060315 Maturker 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Easternshore Dr Salisbury MD 21804 Mahesha Thimmarayappa M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 2 2004 oaks Registrar

			For State Registrar	State of Maryland		ment of F			giene Reg. No. 200	4 62360
	Physici /Medio	al	Decedent's Name (First, Middle, Las	n. Gelo	ger		r Location of Death	2. Date of De. Month		7 1120
	Examir Funeral Director	ier	5. Social Security Number 6. Se 148 - 14 - 5845	oice athe La	ake ast birthday) If	Under 1 Year onths Days	Sburt If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	Wic	Birthplace (State or Foreign Country) W Jersey
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicon		Town or Location	on				10d. Inside City Limits 1 ☐ Yes 20No
	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. int: If item 27 is marked other then "neturel", or items 23a or 28a-f show ity or other treumatic event, the Madical Examine manual the motified at	Dire	10e. Street and Number 8581 Middlese:			Of. Zip Code 21	875		10g. Citizen of What	Country?
5-0036		by Funeral	11. Marital Status  1 ☐ Never Married 2★ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ॲ No If Yes, Give Year or Dates:	1	Decedent of H s, specify Cuba Yes 2 X No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. Race - A Black, W Specify: W	
21215-0		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+)	16a. Decedent' (Give kind life. DO I	of work done o NOT use retired	ation during most of wor f)	king	16b. Kind of Busine	ss/Industry
Maryland		To Be (	17. Father's Name (First, Middle, Last) Harold Jacob				Edna	Slater		
Baltimore, Mar			19a. Informant's Name/Relationship (7.  Fred K. Geiger/ 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 1 U Donation 5 □ Other (Specify	husband 20b. Pla 20b. Pla Removal from State		Middle	esex Dr.		ar, City or Town, State nar, MD 2 20c. Location - City Parsons	1875
Baltii	permit. Pag Department Importent: If any injury o		21. Signature of Funeral Service Licens	or CFSP	Hol 501	Snow	Funeral Hill Ro	ıSal	isbury,	onal Assoc. ID 21804
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s, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours attended to 24 hours attended to 25 hours attended to 25 hours attended to 25 hours attending physician and 25 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 25 hours at 25 ho	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque						
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Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, f	actory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
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			For State Registrar		Stat	e of N	/larylan	d / Depa <i>Cei</i>	artme <i>tifica</i>	nt of Hotel	ealth Deati	and M h	lental Hy	giene Reg. No	20	04	42361
			1. Decedent's Name	(First, Middle, I	Last)								2. Date of D	eath Da	v	Year	3. Time of Death
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	Examin		4a. Fecility Name (If	not institution, g	give street ar	nd numbe	or)		4b. Cit	y, Town, or	Location	n of Death		4c.	County o	of Death	
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	Funeral		5. Social Security No	umber 6	. Sex	7 - 1		last birthday)	If Und Month		If Under	er 24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)		Cour	lece (State or Foreign
	Director		341-10-67		1 □ M 2 □ X		86	Yrs.					Jan 16	, 19	18	[11i	nois
	pur *		Usuel Residence of 10a, State	10b. County			10c. Cit	y, Town or Lo	cation							1	0d. Inside City Limits
	sho	ö		34				1 # 1 :	1 -								1 ☐ Yes 2 ☐ No
	28a-	Director	Maryland  10e. Street and Num	Montgo	mery		K	ockvil.		ip Code				10a. Cit	izen of W	hat Cour	ntry?
	with with	₫	1803 Clif		Max					2085	/ı				ited		•
	ne 23	Funeral	11. Marital Status	re urrr	12. Was		nt Ever in U	.S. 13. \	Was Dec	edent of Hi	spanic (	Origin? (Sp	ecify Yes or N		14. Race	- Americ	an Indian,
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21215-0036	within 72 hours after death with the Maryland one. then "natural", or Iteme 23a or 28a-f show then "natural" or Iteme 23a or 28a-f show ite Mailcal Exertifier rotal ite notified at	ted	/Sana	15. Decedent's ify only highest		leted)		16a. Deced	dent's Us	ual Occupa	ition	ast of work	ina	16b. K	ind of Bus	iness/In	dustry
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pu	d oth	Be	17. Father's Name (	First, Middle, La							18. Mol		e (First, Middle			)	
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Baltimore,	or of		1 ⊠ Burial 20	Cremation 3		from Sta	te	emetery, crer	natory o	other place		10/00	10001				
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of \	Physic this or al dire	2	1 ☐ Yes 2		Hospital	1 Lunpa		ER/Outpatier			41.	Nursing Ho	me 5 Res				y)
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Division of	or At fiter of Direct in by	Certification:	4 Homicide	determin	ed 28e.	building,	etc. (Speci	ome, farm, str fy)	eet, fact	ory, office			City or To			r or Hura	il Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ce	29a. Certifier	1 Certifying	Physician	To the he	est of my key	owledge death	h occurr	ad at the time	ne date	and place	and due to the	causolo	) and man	ner se s	tated
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	ithin o the	Me	29b. Signature and	title of certifier			1 1	1- 0		29c. License	numbe	)r		29d. Da	te signed	(Month,	Day, Year)
	H3 H 8		Pada	ticid	loms.	Ke-	May	, mx	7	D	5/9	7/6		De	C	20,	2004
	5		30. Name and addr	ess of person w	ho complete	d cause o	of death (Iter	n 23a) (Type	Print).	1, 1.	N. 1			1	, ^	//	
			Patrici	a Tom	6.	Vay,	11119	Rock	VII	le l	ike	, 6-	100, 1	(OC)	KUII	le,	2004 MD 20852
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			1 - For State Registrar	State of Maryl		partment of leartificate of			giene	1 12362
	Dhoolei		Decedent's Name (First, Middle, Last	st)				2. Date of Dea Month	th _	3. Time of Death
	Physicia /Medic		LENA REBECCA GALE					DEC 21	, 2004	8:05 p <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of D	Death	4c. County of D	eath
-	Funeral	-	3040 E OCTOBER PLA 5. Social Security Number 6. S		rs. last birthday			Hrs. 8. Date of Birth	CHARLES	Birthplace (State or Foreign
	Director		216-36-6858 19 Usual Residence of Decedent	□ M <b>X</b> □ F 68	B Yrs.	Months Days	Hours	Min. 8. Date of Birth (Month, Day APRIL 2	1936 C	Birthplace (State or Foreign Country) HARLES
	within 72 hours after death with the Maryland ene. Itan "natural", or Items 23a or 28a-f show the Medical Epain, not must to motified at		10a. State 10b. County	10c.	City, Town or L	_ocation				10d. Inside City Limits
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	with th	Directo	10e. Street and Number			10f. Zip Code			log. Citizen of What	•
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9	after o	by Funerai	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No		If Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)	Black, W	
003	ural',		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: B	LACK
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	e filed al Hygid othar vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, I		
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ē	Pages nent of int: If Its iry or o		1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State		ematory or other pla	1			
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	ny sician /Medical /Medical Examiner   the prival-transit   the prival-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a cons b. Due to fracs a cons c. Due to (or as a cons d.	sequence of):	s. on	art I	islase		Onset and Death
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	To the Hospital or Attanowithin 24 hours after death To the Funaral Diractor: completely filled in by the	Me	29b. Signature and title of certifier			29c. Licens	se number	29	ed. Date signed (Mo	nth, Day, Year)
			yania m.	Tayour.	40	D60	5550	883	Dec. 23.	2004
m	P	H	30. Na e and address of person who o	complet cause of death (I	tem 23a) (Type	Print) pr	206	46		
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1	B1 -1-1		1. Decedent's Name (First, Middle, Last	)				2	Date of Dea			of Death
	Physici /Medi		Brian Stephen Gra	nville				I	ecembe		9ar 004 8:46	Б Р <sup>м</sup>
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of			4c. County of	Death	
			30240 Dudley Road	l			nicsvi				Mary's	
	Funeral Director		214-21-7125	x 7. Age (In )	yrs. last birthday) 20 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. A	Date of Birth (Month, Day, pril 1	Year)	. Birthplace (State Country) Maryland	
	and *		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or Lo	cation					10d. Inside	City Limite
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	the t	Funeral Director	MD St. Mary  10e. Street and Number	'S Me	echanics	10f. Zip Code			1	0g. Citizen of Wha		
	With Williams	0	30090 Dudley Road			20659	a				1	
	leath	era	11. Marital Status	12. Was Decedent Ever i	in U.S. 13. V	Was Decedent of H		in? (Specif	v Yes or No-	U. S. A	American Indian,	
"	r iter	듄	t⊠Never Married 2 Married	Armed Forces? 1 ☐ Yes 2€ RNo		Yes, specify Cub	an, Mexican,	Puerto Ric	an, etc.)		White, etc.	
036	el', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I∐Yes 2⊠ No	Specify:			Specify:	White	
21215-0036	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show died Eventiner mast be notified at	Completed by	15. Decedent's Edu (Specify only highest grad	ication	16a. Deced	lent's Usual Occup kind of work done	pation	-6		16b. Kind of Busin		
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Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If flem 27 is marked other then "naturel", or items 23e or 28e-f show or other treumatic event, the Medical Examiner mast be notified at	P	David Stpehen Gra				L			LaManna		
Jar	and and		19a. Informant's Name/Relationship (T)							, City or Town, Sta		
	1 and 1 Health em 27		Catherine A. Thom  20a. Method of Disposition		b. Place of Dispos					11e, MD 2		
Baltimore,	ges if of h		1 🖾 Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crem	natory or other pla		ecemb	1.	20c. Location - Cit	y or lown, State	
ţ	t. Partmer		'4 □ Donation 5 □ Other (Specify)		Crinity M			3, 20		Waldorf,	Maryla:	nd
Bal	permit. Pages 1 an Department of Heal Importent: if Item 2 any injury or other		21. Signature of Funeral Service Licens	_	100641 30	Name and Addre	ess of Facility	Brin	sfield	-Echols I	Funl.Hme	.,P.A.
			23a. Part1. Enter the disease, or compl							lotte Hal	Approxima	
			shock, or heart failure. List only of	ne cause on each line.		an the mode of dyn	ig, such as ca	artilac or re	A spiratory arre	981,	Interval Be	etween
	Physician /Medical		disease or condition resulting in death)	. Jun	Shot (	Nound	at	Heo	Z			
ı	Examiner			Due to (or as a con	sequence of):							
	-	-E-	Sequentially list conditions, if any, leading to immediate	Due to (or as a con:	sequence of):							
	nsit	듵	cause. Enter Underlying Cause (Disease or injury									
Ć,	executed n and ial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a con:	sequence of):							
9289				4								
99	death certificate be e attending physicia of for use as the bur	Physician/Medical							3000			
Box	n cert andin use	N/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre						23d. Date of	delivery	
	death e atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F		Ectopic pregnancy Other (specify) _	<i>y</i>			Month	Day	Year
P.0	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown								
	The law requires that the tee has been signed by the age 2 should be detache	by F	Part II. Other significant conditions con	ntributing to death but not	resulting in the un	iderlying cause giv	en in Part I.		23e. Did tob	acco use contribu	te to the cause of	death?
ord	w requir been si should								1 ☐ Ye	s 2/12/No 3[	Probably 4	]Unknown
ecc	e fawr has be je 2 sh	ple							24a. Was ar		e autopsy findings	available
m —		Completed							A perform	ned? deat	h? Yes 2 No	Lause of
Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of	of Death (C	heck only one			
of V	Physic this ce al dire	70	Yes 2 No	lospital: 1 Inpatient 2	2 ☐ ER/Outpatient	3□ DOA Oth	ler: 4 ☐ Nurs	ing Home	5 🗌 Reside	nce 6 other (s	Specify) at :	scene
	ding Ph h. After th funeral	:uo	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Yonth, D, y Year	28b. Time of Injury	28c. Injur Wor	y at k?	28d	. Describe ho	w injury occurred	,	
Division	Attending ir death. ector: After by the fune	Certification;	2 Accident investigation	142404	७५०		Yes 2 No		ubje	of Shol		
$\leq$	or Attendate death Director:	riff	3 Suicide 6 Could not be determined	28e. I lace of Injury - A building, etc. (Spe	t home, farm, stre		- 8	28f.	Location (Str City or Town	re t and Number o ( tate)	r Rural Route Nui	nber,
	urs a		20 0 17			lence		10	540	welley	H) 20	659
	To the Hospitel or within 24 hours after To the Funerel Directoropletely filled in the completely  edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exami	sician: To the best of my liner: On the basis of exam	knowledge, death nination and/or inv	occurred at the tir estigation, in my o	ne, date and p pinion, death	place, and occurred a	due to the ca	use(s) and manne ite and place, and	r as stated. due to the cause	s)	
	thin 2 the mple	Med	29b. Sign the and title of certifier.	and manner stated.		29c. Licens				9d. Date signed (M		
)	T wi		V ( land	. 1			.C.M.E.			ecember 2		
7	1		20 Name and the	MI)	h ac : ==		· C·FI·E·	•	D	CCEIIDEL A	2004	
y/\.	195		30. Name and address of person who co	cause of death (I	item 23a) (Type, F 111 T	rınt) Penn Stre	eet. Ba	altim	ore, M	aryland 2	21201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regionar's Si								
	Registr				JK A	boute						

D			1 - State Unpend Ttem 7	State of Mar	yland / Depa <b>me<sub>no</sub>G839</b> el	artment of H	lealth and M Death		giene Reg. No.	0.1		
	Physici /Medio		Decedent's Name (First, Middle, Last)     MARTINEZ ELISHA GE					2. Date of De Decembe	ath CU	J 4 .004	915 A м	
	Examir		4a. Facility Name (If not institution, give s Civista Medical Cer	treet and number)		4b. City, Town, or LaPlata	Location of Death		4c. County Charl			
	Funeral Director		5. Social Security Number 6. Sex 215-71-0095	7. Age (	In yrs. last birthday) Yrs.	If Under 1 Year Months Days 2 3	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCIOBER 2	y, Year)	9. Birthpl Count MARY	* *	
	laryland show		10a. State 10b. County	1	0c. City, Town or Lo	cation				10	Od. Inside City Limits	
	Man 9-f sh	ģ	MD CHARLES	V	VALDORF						1 Yes 2 □ No	
	death with the Maryland ms 23a or 28e-f show frast be restified at	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	try?	
	ath w	ia [	12155 ELL LANE, AP			20602 UNITED STATES						
920	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Items 27 is marked other than "natural", or items 23a or 28e-1 show other treumatic event, the Marical Examiliating at	by Funeral Director	11. Marital Status  1 X Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Event Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	ispanic Origin? (Spi in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Race Blace Specify	e - America k, White, e		
5-0	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupa	ent's Usual Occupation 16b. Kind of Business/Industry					
21215-0036	l within iene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	a. DO NOT use retired)						
Maryland 2	should be filed withir ad Mental Hygiene. marked other than matic event, ITEM.	To Be C	17. Father's Name (First, Middle, Last) G	REGORY MAI		18 Mother's Name (First Middle Maiden Surgame)						
lary	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (Type	oe, Print)	1		and Number or Rura	al Route Numbe	ar, City or Town,			
	1 and Health Nm 27 Iher tr		EUNA V. WHALEN / M	OTHER	12155 20b. Place of Dispo		E, #54, W				0602	
Baltimore,	Page nent o ant: If ury or		1 ☐ Burial 2 ⚠ Cremation 3 ☐ R.  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	THE HUNTT	natory or other place	RY JANU	ARY 6, 005	WALDORF	-		
Balt	permit. Departr Importr any inj		21. Strurge of Fund all Seminories	JOHNSON	M00583 3	HORNTON F 439 LIVIN	UNERAL HO	OME, P.A D, IND	A. LAN HEAD	, MAR	YLAND 20640	
1			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the cause on each line.	e death. Do not ente	er the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sudden In	nfant Deat	h Syndron	ne				Onset and Death	
	/Medical Examiner		Toodking in dodain,	Due to (or as a d	consequence of):							
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence of):							
	cuted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
oʻ	be executed ician and burial-transit	EX	resulting in death) Last	Due to (or as a c	consequence of):							
8760,	cate be ex ohysician the buria	dicai	d									
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of 1 Live birth 2   4 Pregnant at tin 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	of deliver	<b>y</b> Day Year	
Ω.	ires that the signed by	by	Part II. Other significant conditions con	tributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contri	bute to the		
Records,	w requir been si should	letec						24a. Was	. \		sy findings available	
									pletion of cause of			
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only o	ne)			
of \	Physic this c	P	1 X Yes 2 □ No	ospital:	ER/Outpatien		4   Nursing Ho		lence 6 □Othe			
UC.	ding F	ion	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injury Work	rat <br Yes 2 □ No	28d. Describe h	iow injury occurre	ed		
Division of	Attending If death. ector: After by the fune	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, stre			28f. Location (S	Street and Numbe	or or Rural	Route Number.	
Ö	s after	Certification:	4  Homicide determined	building, etc. (	(Specify)	*		City or Ton	m, State)			
	To tha Hospital or Attending Physician: within 24 hours after death. To tha Funerel Director: After this certific completely filled in by the funeral director.	edical (	29a. Certifier (Check only one) Certifying Phys 24 Medical Examin	ician: To the best of reer: On the basis of example and manner state	camination and/or inv	occurred at the tim restigation, in my op	ne, date and place, a pinion, death occurre	and due to the o	cause(s) and mar date and place, a	nner as sta nd due to t	ted. the cause(s)	
	To the To the Comp	ğ	29b. Signature and title of certifier	1.0		29c. License			29d. Date signed	(Month, D	ay, Year)	
•			Carol	Halla	und	O.C.M.	.E.		January	1, 20	005	
The	B		30. Name and address of person who con	mpleted cause of dear	th (Item 23a) (Type, 11	1 Penn St	reet, Bal	Ltimore	, Maryla	nd 21	201	
	State Registrar JAN C 5 2005 32. Figure 1 State State 1 State											

			1 = For State Registrar			nd / Depa		t of H	ealth a	and M	lental Hy	giene		10.	1 0	
	_		Registrar  1. Decedent's Name (First, Middle,	Last)		Oe.	rincale	9 01 1	Jean		2. Date of De	Reg. No.	UU	1.3	3 Time	of Death
	Physici		Mark Hilton Gol								Month December	r 13	. 20	04	9:30	0 P M
	/Medic Examin		4a. Facility Name (If not institution,		er)		4b. City,	Town, or	Location of	of Death			County of			
			Suburban Hospit	:al			Beth	esda	ı			P	rince	Ge	orge'	S
	Funeral Director		5. Social Security Number 578-56-2531	5. Sex 7. 1 X M 2 □ F	Age (In yrs	i. last birthday) 2 Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird (Month, Da April 8	th y, Year	42	Birthp Coun Wast	lace (State try) 11ngt(	or Foreign
	tryland thow	_	Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	ocation							1	0d. Inside (	
	Ba-f s	Director	Virginia		A1	exandr										s 2 No
	with th	Dire	10e. Street and Number	"			10f. Zip						zen of Wh	at Coun	try?	
	eath res 23	eral	2121 Jamieson Av	7e - #503	ent Ever in I	IIS 13	Was Deced		cnanio Orie	gin? /Sn/		U.S.		Americ	an Indian,	
30	be filed within 72 hours after death with the Maryland stal Hygiene. do other then "natural", or items 23a or 28a-1 show event, the Mudical Examinar must be modified at	by Funeral	1 ☐ Never Married 2 ☑ Marrier 3 ☐ Widowed 4 ☐ Divorced	Armed Force	es? No		If Yes, spec		Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Black,	White,		
9200-91212	2 hou		15. Decedent's	Education		16a. Dece	dent's Usua	I Occupa	ation			16b. Kir	nd of Busi			ī
22	within 72 ene. then "nat	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	or 5+)	(Give	kind of wor DO NOT us	k done d e retired	luring most )	t of worki	ng				,	
	ygiene ygiene ar th	Con		5+		Progr	ram Ar	nalys						Gov	ernme	ent
	be filed value of the dother if	Be	17. Father's Name (First, Middle, La	ast)							(First, Middle,	Maiden	Sumame)			
<u>\</u>	2 should be f and Mental H Is markad of raumatic eva	<sup>6</sup>	Leon Goldman			10. 11.00		10			Love	-				
Maryland	s 1 and 2 should if Health and Mer itam 27 is marks other traumatic		19a. Informant's Name/Relationship Gloria Ann Cante	* **			-				il Route Numbe 3 Alexa					
as	of Health of Health itam 27 I		20a. Method of Disposition	or broad		Place of Dispo					ate		cation - Ci			
Baltimore,	permit. Pages 1 Department of H Importent: If its any injury or ots		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		4169	cemetery, crei xon Hil			- 1	12/1	6/2004	Oxon	н 11	1. M	D	
	artme orter injur		21. Signature of Fuheral Service Lie		0		2. Name and				efferso					
ñ	Der Per		Kobert	الاع ع	and	2	5755	Cas	t1ewe		Dr. Al				_	. 5
J,	Physician		23a. Pert1 Enter the disease, or construction of the shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on eac	h line.	n Resis						rest,			Approxima Interval Be Onset and	etween
	/Medical		resulting in death)	a		quence of);	cano	Juar								
	Examiner	_	Sequentially list conditions,	<sub>b.</sub> Pneum												
	ed isit	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Date to (or	as a cunsu	cuanda of):										
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or	as a conse	quence of):										
6876U,	ate be executed hysician and the burial-transit	caiE														
200	ificate g phy as the	edlo		0.												
ŏ	death certificate e attending physi d for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco 1 ☐ Live birt			Ectopic pre	anancu				2	3d. Date o	of deliver	ry	
<u>a</u>		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnan	t at time of		Other (spe						Month		Day	Year
т Э	at the	Phy	9 Dunknown													
cords,	w requires that the des been signed by the a should be detached f	þ	Part II. Other significant condition	s contributing to deal	th but not re	sulting in the u	nderlying ca	iuse give	in in Part I.						e cause of ably 4	
ဝပ	> 0 0	ompleted									24a. Was		24b. We	re autop	sy findings	available
Ï	0 - 0	mo									autop perfor	rmed? 2 A No	dea	th?	spielion of c 2🕅 No	Jause of
VIII	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?							of Death	(Check only o					
010	ding Physician: h. After this certifici	P.	1 ☐ Yes 2X No	Hospital: X Inp		ER/Outpatier		- American	4 🗀 1401		ne 5 🗆 Resid			(Specify	)	
		lon:	27. Manner of Death 1 X Natural 5 ☐ Pending		Injury Day Year)	28b. Time of Injury		Bc. Injury Work	_		28d. Describe h	iow injury	occurred			
VISION	ttan deatl stor: the	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be Goo Diago of	Injuny . At I	home, farm, str	M tactory		′es 2⊡N	-	28f. Location (S	troot and	Mumber	or Puml	Pouto Nur	Thor
2	in Direction	Certification:	4 Homicide determin	ed 209. Flace of building	, etc. (Spec	eify)	eet, factory,	, ornce		1	City or Tow		TYUTTIOUT I	or nurar	Noute real	iber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier 1X Certifying (Check only one)	Physician: To the be caminer: On the basi and manner	is of examin	nowledge, death nation and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the d ad at the time, o	cause(s)	and mann place, and	er as sta I due to	ited. the cause(:	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 .		- 40	29c.	License	number			29d. Date	signed (/	Month, D	Day, Year)	
			> Valyaan	ayonia		7 7	D-	-276	60			1	2/ /	4/00	1	
)	(12)		30. Name and address of person wi	no completed cause	of death (Ite	m 23a) (Type,	Print)		0	1 -	70 '		-1	11		
_			41PANA GOSW	JAMI	111	19 Roc	ckul	110	ike	1610	T Kock	UIL	12 N	10	205	52
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 7 20	04 Reg	istrar's Sign	nature	E				r Rock					

			For State Registrar		partment of Health and I	, ,	ene . No 2 11 11	1.2267
	Dhusis	À	1. Decedent's Name (First, Middle, Las	()		2. Date of Death Month	- 000	3. Time of Death
	Physic /Medi		Virginia Lee Gil			DECEM BE		6:50 p M
7	Exami	ner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	, •	4c. County of Death	1
	-		Lorien 6. Se  5. Social Security Number 6. Se	XIVERSIDE  7. Age (In yrs. last birthda	(v) If Under 1 Year If Under 24 Hrs.	P Date of Birth	Harto	
	Funeral Director			☐ M 2□XF 84 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y April 22,	ear) 9. Birth	place (State or Foreign intry) VA
	pu ,		Usual Residence of Decedent			TOPECCE 22,	1720	VA
	with the Maryland a or 28a-f show	70	10a. State 10b. County	10c. City, Town or				10d. Inside City Limits
	the M	Director	MD Cecil  10e. Street and Number	Rising	Sun 10f. Zip Code	100	0	1 Yes 2 No
	3a or		47 McGrady Road	d	21911	109	. Citizen of What Cou USA	ntry?
	ier death w items 23a her must t	Funerai	11. Marital Status		B. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ameri	can Indian,
36	or ite	y Fu	1 Never Married 2 Married	1 _Yes 2 X No	1 ☐ Yes 2 ☒ No Specify:	o Hican, etc.)	Black, White,	
ő	be filed within 72 hours after death with the Maryland ital Hygiene. ud other than "natural", or Itlams 23a or 28a-f show evant, the Mactical Examinar must be notified at	ed by	3 Widowed 4 □ Divorced	Year or Dates:				
15	nin 72 n "na	Completed	15. Decedent's Edu (Specify only highest grad	de completed) (Gi	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired)	king 16	b. Kind of Business/In	dustry
212	d with giene	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	nemaker		Own Home	
pu	al Hy d othe	Bec	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai		
<u> </u>		To	James Millard Fw			i Farmer		
Maryland 21215-6036	s 1 and 2 should f Health and Men itam 27 is marka other traumatic		19a. Informant's Name/Relationship (T)  Carolyn J. McQuit		Iling Address (Street and Number or Ru			Code)
	s 1 an f Heal ftam 2 other	- 8	20a. Method of Disposition	20b. Place of Dis	McGrady Road, Risk position (Name of ematory or other place) 12-30		D 21911 D. Location - City or To	own. State
9	Pages ent of nt: If i		1 ☐ Surial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	ISINOVALIIOIII OLAIS	<sup>rematory or other place)</sup>  12-30 Etinaham Cemetery	7-2004		
Baltimore,	permit. Pages 1 and 2 of Department of Health ar Importent: If item 27 is any injury or other trauone.		21. Signature of Funeral Service Licens	West Not	22. Name and Address of Facility R. 7	English E	Colora, Mi	, D A
<u> </u>	8258	1 3	Krehard L.	No o'a	III S. Queen St.,	kusung Su	n, MU 219	)11
				lications that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a HENING DE	ment7A			Onset and Death
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	ocuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c				
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687	ate hys the	dicai		d				
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delive	
	death e atte	by Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
P.0	that the d ed by the detached	Phys	9 🗆 Unknown	9□ Unknown				
	w requires that been signed b should be det		Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to th	
Sorce	requi	eted				1 🗆 Yes	2 No 3 Prob	ably 4 Denknown
Records,	e la has	ompieted				24a. Was an autopsy performed	2 to. Were autor prior to con	psy findings available inpletion of pause of
Vital	ician: Th certificate rector, pag	e Co	25. Was case referre to medical			1 ☐ Yes 2 🗹	No 1 ☐ Yes	2110
ί	S S	ToB	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	_ Other	h <i>(Check only one)</i> me 5 □ Besidence	6 ☐Other (Specify	-
n of			27. May er of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in		
Division	Attanding r death. actor: After	cati	2 Accident investigation 3 Suicide 6 Could get be		M 1 ☐ Yes 2 ☐ No			
<u>N</u>	l or Ail after d Dirac	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
	Hospital	aic	29a. Certifier 1 Certifying Phys	sicien: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the cause	a(s) and manner as st	ated
	To the Hospital or Attand within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	(Check only 2 Medical Exemination one)	ner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	2.	29c. License number	29d. l	Date signed (Month, L	Day, Year)
	A	-	Prigup Sil	M 14.7.	1)40412		12/2/1/2	+
	2		30 Mine and address of derson who co	empleted cause of death (Item 23a) (Type	Print) ALON ALDE	Ani.	Ma	10781
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature	A OF TIVE	11/10	(V   V	V 78
	Registra		DEC 2 8 2004	new of specie				

		State of Maryla	and / Depa		ealth and M	ental Hygie	ne	
		Registrar  1. Decedent's Name (First, Middle, Last)		rtificate of L	Jeath	Reg.	No. 2004 423	368
Physicia /Medic Examine	al .	HAROLD J. GERMAIN  ta. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death			<sub>Вр</sub> м
Examine	er	Chester River Hospital C	enter		ertown		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 120 M 2 F 7. Age (In y. 75)	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	Kent  9. Birthplace (State or Country)  New York	Foreign
land	-	Jsual Residence of Decedent           10a. State         10b. County         10c.	City, Town or Lo	ocation			10d. Inside City	Limite
the Mary 28a-f she	Funerai Director	360	Rock Ha	11			1 <b>x</b> Yes 2	
with Sa or	בַ	21835 Sunnyside Ave.		10f. Zip Code 21661		1	Citizen of What Country?	
death	era	11. Marital Status 12. Was Decedent Ever in	U.S. 13.1	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec		U.S.A.  14. Race - American Indian.	
15-0036 72 hours after death with the Maryland "natural", or Items 23s or 28s-1 show olded Exartimetriust be nutified at	Ď.	Armed Forces?  1 ☐ Never Married 2 ☑ Married  1 ☐ Yes, Give  3 ☐ Widowed 4 ☐ Divorced Year or Dates: KO		lf Yes, specify Cubar 1 ☐ Yes 2 <b>X</b> No		Rican, etc.)	Black, White, etc.  Specify: White	
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, If e M. die, Experi	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired)	tion uring most of workin	la l	hemical	
d 212 filed with Hygiene. Hygiene. with ar than	Con	12	Seni	or Syst		rst M	anufacturer	
and the file of othe evant.	m l	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	den Sumame)	
arylan	0	Harold Germain  19a. Informant's Name/Relationship (Type, Print)	40) 44-15		Anna Co			
re, Marylc s 1 and 2 should f Health and Mer itam 27 la marke othar traumatic		Michael Germain (son)					ty or Town, State, Zip Code) 210	661
othar	-	20a. Method of Disposition 20b	Place of Dispo	sition (Name of natory or other place	Da		1 0 00 00	VY.
Pages ment of I		1 ☐ 8urial 2 ☐ Cremation 3 🗷 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	t. Mar	y's Ceme	tery 12	/31/04	South Glens Fa	
Baltimore, permit. Pages 1a Department of Hee Important: If itam any injury or otha		21. Signatur 1 Funeral Service Chanses  MOO:	-10 G	. Name and Address	s of Facility neral Ho	ome of S	Stephen L.Scha	
176 Ite be lysiciz	Cal Ex	23a. Pan1. Entel the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last  Due to (or as a consequence of the conditions o	ath. Do not enter equence of):	er the mode of dying  CO  DM	, such as cardiac or	respiratory arrest,	Approximate Interval Between Super and Dec	en ath
P.O. BOX 6 nat the death certific d by the attending p letached for use as		FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	tal déath 3□	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Yea	ır
urres that urres that signed b id be deta	2	art II. Other significant conditions contributing to death but not re	sulting in the un	derlying cause giver	in Part I.		o use contribute to the cause of deat 2 No 3 Probably 4 Wunk	
The law requires t rate has been signe page 2 should be considered.	mbiere					24a. Was an autopsy	24b. Were autopsy findings ava	
n: The ficate or, page		5 Was and the state of the stat				performed? 1☐ Yes 2.	death?	
vician s certifi		5. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospital: 1 \( \subseteq \text{Inpatient} \) 2 [	☐ ER/Outpatient		26. Place of Death (		2 Tal. (2	
lor Attending Physician: The affer death.  Diractor: After this certificate he in by the funeral director, page		7. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28b. Time of Injury	28c. Injury a Work?	at 28	d. Describe how in	6 ☐Other (Specify) jury occurred	
DIVISION ( tal or Attending F is after death. al Diractor: After ed in by the funera		3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At building, etc. (Spec	nome, farm, stre	et, factory, office	28	If. Location (Street and City or Town, Sta	and Number or Rural Route Number, te)	;
n 24 hound he Funar	2000	9a. Certifier (Check only one)  1  Certifying Physician: To the best of my kr 2  Medical Examiner: On the basis of examinand manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my opin	, date and place, an nion, death occurred	d due to the cause I at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)	
To the To the company	-	9b. Signature and title of certifier		29c. License r	number	29d. D	Date signed (Month, Dey, Year)	
\ ~				D0061	1321	Dec	ember 28, 2004	4
da 16		o. Name and address of person who completed cause of death (Ite Semra Sahinci, M.D. 420	Pennsy		Ave. Cen	trevil1	e, MD. 21617	
State Registrar		1. Date filed (Month, Day, Year) . 32. Registrar's Sign	ature					

			1 - For State Registrar	State of Marylar	nd / Depa		Health and	Mental Hy	_	04	423	36
	Physic /Medi			Hawkins					6 – 200	Year 4	3. Time of I	Death A N
	Examir Funeral Director	ner	577-36-6331		last birthday) Yrs.	-	Washing to If Under 24 Hrs Hours Min	ton 8. Date of Bir	th y, Year)	P.G.  9. Birthpl	ace (State or try) ington	Foreig
the Maryland	28e-f show cliffed at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland P.G.  10e. Street and Number		ty, Town or Lo	hington				10	0d. Inside City	y Limit
17215-0036 within 72 hours after death with the Maryland	f Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23s or 28e-f show other treumatic event, the Medical Exertains must be notified at	by Funeral Director	100 Alexandria D:	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	10f. Zip Code 207		Specify Yes or No- to Rican, etc.)	14. Ra	S • A • ce - America ck, White, e	an Indian,	
ZIZIJ-UUSO od within 72 hours aft	"neturel", or dical Exand	eted by F	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest g	1 ☐ Yes 2 M No If Yes, Give Year or Dates:  Education 'ade completed)		1 ☐ Yes 2 ☒ No  dent's Usual Occup kind of work done DO NOT use retired	Specify:		Special Specia	fy: Bla	ck ustry	
N g	and Mental Hygiene. is marked other then ' eumatic event, the Me	Be Completed	Elementary/Secondary (0·12) 12th 17. Father's Name (First, Middle, Las	College (1-4or 5+)		n Adminis	strative		Metro Police Maiden Surnai	Depai		
Maryland nd 2 should be file	Ith and Ments 7 is marked treumatic er	To E	Delvin Hawkins,  19a. Informant's Name/Relationship  Jeffrey B. Wise/	(Type, Print)	19b. Mailin 1001	g Address (Street) 5 Highla Washin	Edna Ma and Number or Ru nd View	ural Route Numbe		, State, Zip (	Code)	
த் மே	Department of Health Importent: If item 27 i eny injury or other tre		20a. Method of Disposition  1 XBurial 2 Cremation 3 (  4 Donation 5 Other (Spec	Removal from State	Place of Dispo: cemetery, cren	Washing sition (Name of natory or other place ion Ceme	ce)	Date	20744 20c. Location Clinto	•		
permit.	Depart Import eny inj once.		21. Signature of Funeral Service Lice  Wanda C  23a. Part1. Enter the disease, or core  and the cit benefit followed in close on the cit of the	Bacon, CC3	61 34	Name and Address	St., N.W	. Wash.,	D.C. 2	20010		
/N Ex	Medical amminer transit the private transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq	uence of):		(EC	or respiratory an	est,		Approximate interval Betwee Onset and De	eath
that the death certificate be executed	signed by the attending physici be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3 aeath 5	Ectopic pregnancy Other (specify)	en in Part I	23a Did to			ay Yea	
The law requires that the	2 should	Completed by						10	es 22No	3 ☐ Probat	oly 4 □Unk	known
Physicien: The law requires t	ertificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:		3C DOA Othe	and the same of th	perform 1 Yes :	რed? 2 X No 1999 (θ)	death?	óletion of caus ☐ No	56 01
ng Phy	ctor: After this the funeral di	Certification; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \( \)	at Nursing M	ome 5 Reside	ow injury occurr	ed		
To the Hospitel or A	n by	edical Certif	4 Homicide determined  29a. Certifier (Check only 2 Medical Exa	building, etc. (Specify  nysician: To the best of my kno- miner: On the basis of examinal	v) wledge, death	occurred at the tim	e, date and place,	28f. Location (St City or Town	n, State)	nnor on etch		<i>r</i> ,
To the	To the		29b. Signature and title of certifier	Mosking Are		29c. License			9d. Date signed			
(1)			30. Name and address of person who	completed cause of death (Item	23a) (Type, P			7 W6	shin who	MD	20744	
	Stat Registra	·C	31. Date filed (Month, Day, Year)  NFC 2 8 2004	32. Registrar's Signal	enure Local	2				·	-1-	

		•	1 - State of Maryland / De State of Maryland / De State	partment of Health and Me ertificate of Death	ental Hygier Reg. l	2004 4/3/0
	Physicia /Medic		Decedent's Name (First, Middle, Last)  Joan Townshend F.		Date of Death Month December	Day Year 3. Time of Death 1:30 A. M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) $ 2303 \   \text{Dartmouth Lane} \\ 5. \text{Social Security Number} \qquad \begin{array}{c c} 6. \   \text{Sex} & 7. \   \text{Age (In yrs. last birthology)} \\ 1 \   \text{M} & 2 \   \text{$\mathbb{Z}$} \end{array} $	Months   Days   Hours   Min.		4c. County of Death  Anne Arundel  9. Birthplace (State or Foreign Country)
	Aaryiand f ehow ed al	or	Usual Residence of Decedent  10 State  10b. County  10c. City, Town of City and City			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the N 3e or 28a-	i Director	10e. Street and Number 17 Marlin Dr.  2303 Dartmouth Lane	10f. Zip Code 087	<b>21</b> US	Citizen of What Country?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28a-f ehow any injury or other treumatic event, "he Medical Evan met must be notified at once.	by Funerai		3. Was Decedent of Hispanic Origin? (Specifl Yes, specify Cuban, Mexican, Puerto Ri		14. Race - American Indian, Black, White, etc. Specify: White
21215-0	d within 72 ho giene. In then "natur Ine Madical.	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired)  Real Estate Agent	'	. Kind of Business/Industry  Real Estate
yland	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last)  Curtis S. Townshend		len Parry	у
e, Maryl	t and 2 shu Health and Im 27 is m		Kim Keale - daughter 23	ailing Address (Street and Number or Aural A  D3 Dartmouth Lane, Co  sposition (Name of Dat	rofton, N	
Itimore,	iit. Pages artment of P ortant: If Ite injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	litan Crematory 12-27	-04 Al	lexandria, VA.
Ba	Pering any song		23a. Part1. Enter the disease, or complications that caused the death. Do not	6512 N.W. Crain Hwy		, FId. 20715 Approximate
68760,	Physician /Medical Examiner  by physician and prize transit is the prize transit.	edical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)  Due to (or as a consequence of)	cardiovascula and a ortic e vascular dia ocis	r dig diseas	Interval Batween Onset and Death Uncteur  Culturun Unknown
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph. page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
	equires that the signed by ould be detacted	by	Part II. Other significant conditions contributing to death but not respitting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Vital Records,	n: The law r cate has be r, page 2 sh	Completed			24a. Was an autopsy performed 1 Yes 2	
Division of Vit	To the Hospitel or Attending Physicien: The lawinin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, farm building, etc. (Specify)	e of 28c. Injury at 28. Work?  M 1 Yes 2 No	9 5 ☐ Residence d. Describe how in	njury occurred  and Number or Rural Route Number,
٥	Hospitel or A 24 hours after Funerel Dire stely filled in by	edical Cert	29a. Certifier  (Check only   Medical Examiner: On the basis of examination and/c		d due to the cause	e(s) and manner as stated.
)	To the P within 24 To the F complete	Medi	29b. Signature and title of pertifier  30. Name and address of person who completed gause of death (Item 23a) (Ty	29c. License number \$20138	29d. (	Date signed (Month, Day, Year)
N	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 8 2004	3 N. Calvert St.	# 570	Baltimore MA

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:30 A M MARION HIMELFARB DECEMBER 16, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3200 NORTH LEISURE WORLD BLVD #220 SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPT 19, 1 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2√2F 87 577-09-0786 Director 1917 WASHINGTON, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-1 show MARYLAND MONTGOMERY SILVER SPRING 1 ☐Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 3200 NORTH LEISURE WORLD BLVD #220 20906 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 No WHITE þ Specify 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY GOODMAN ROSE KESSLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN H. HAYMAN/DAUGHTER 15 ARLIVE COURT, ROCKVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GDNS 12/19/2004 1 4 ☐ Donation 5 ☐ Other (Specify) OLNEY, MARYLAND 21. Signature of Funeral EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCLERATIC CARDIOVASCULAR DISEASE disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury The taw requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the at 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2X No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗆 No 1 Yes 2 XNo To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 10 28a. Date of Injury (Month, Day Year) iaral Director: After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funaral Dire 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and Alle of certifier

DR. BENJAMIN/AVRUNIN, 18111 PRINCE PHILIP DRIVE, OLNEY, MARYLAND 32. Pegistrar's Signature

29c. License number

D08381

29d. Date signed (Month, Day, Year)

**DECEMBER 17, 2004** 

		200	1 - For State Registrar	State of Maryland	Depa <i>Cer</i>	irtment of H tificate of L	ealth and N Death		iene () (	Ļ	2373
I	Physici /Medio		1. Decedent's Name <i>(First, Middle, Last)</i> Patrick	Dwight		Huff		2. Date of Death Month December	Day	Year 004	3. Time of Death 7:30AM M
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County		•
	Funeral Director		Bradford Oaks N  5. Social Security Number 6. Sex 233-48-5803	7. Age (In yrs. last	birthday) Yrs.	Clinton  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9 Birthol:	orge's ace (State or Foreign ry) Virginia
	D		Usual Residence of Decedent					Jan. 9	1930	west	Virginia
	within 72 hours after death with the Maryland ene. than "naturel", or itams 23c or 28a-f show he Modeul Examinat must be notified at	7	10a. State 10b. County	10c. City, To						10	d. Inside City Limits
	the M	Director	Maryland Prince Geo	orge's Sui	tland	10f. Zip Code		10	g. Citizen of W	th-10	1 Yes 2 No
	h with 23c or	a Di	3904 Bexley Place	Apt. 309		20746			g. Citizen of W		S.A.
	ams a	iner	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race	- America	in Indian,
36	rs afte	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYPes 2 No If Yes, Give Year or Dates:		☐ Yes 2€ No	Specify:	riibari, oto.,		white, e	
5-0036	2 hou	ted	15. Decedent's Educ	cation 16	Sa. Deced	ent's Usual Occupa	tion	1 1	6b. Kind of Bu		
2	rithin 7 ae. nan "r	Completed	(Specify only highest grade	College (1-4or 5+)	life. L	rind of work done do O NOT use retired)		ing			•
22	filed w Hygier other th	S	17. Father's Name (First, Middle, Last)		Nigr	nt Audito	18. Mother's Name				n Motel
lan	lid ba fental rkad o	To Be	Ralph	Huff			Be11	Chooe	аювп Зитатв	9)	
Maryland 2121	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "nature", or items 23s or 28a-f show or other traumatic event, the Marical Examinat must be notified at		19a. Informant's Name/Relationship (Typ	pe, Print) 1	9b. Mailin	Address (Street ar	nd Number or Rura	al Route Number,	City or Town, S	State, Zip C	Code)
	1 and Health em 27		Vila M. Huff (Wife)  20a. Method of Dispessition			Bexley I					
Itimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or othar once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)			ition (Name of atory or other place	Dec. 2004	•	Oc. Location - (		
alti	permit. Page Department. Important: If eny injury o		21. Signature of Funeral Service License	Lee C	22.	Name and Address			Clintor L HOme.	Inc.	ryland
m	Depar Impor eny ir		Breita D Jil	10 mo1284		6633 Old	Alexandr	ia Ferry	Road C		on, MD 207
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.						10	Approximate nterval Between
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ATHOROSCLE		TIC	ARDIO	ASCUL	AR DIS	EASE,	Onset and Death
B	Examiner		Sequentially list conditions b.	Due to (or as a consequence	e or):						
e	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):						
	xecute and	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequenc	e of):						
09/89	tificate be executed g physician and as the burial-transit		L <sub>a</sub>		,-						
	= 5,0	Medical	IF FEMALE:								
XOR	eath certifica attending plant for use as t	Physician/N	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea		Ectopic pregnancy			23d. Date Mont		
o.	that the de ned by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 🗆	Other (specify)			Mont	11 0	ay Year
ב	The law requires that the death cer te has been signed by the attendir oage 2 should be detached for use	by Pt	Part II. Other significant conditions cont	ributing to death but not resulting	in the und	derlying cause given	in Part I.	23e. Did toba	cco use contrib	oute to the	cause of death?
ord	w require been sig should b	ted t	DAMETES					1 ☐ Yes	2 □ No 3	☐ Probab	ly 4 Unknown
Vital Records,	e law r has be	Completed	SPINAL STE	21804				24a. Was an autopsy	l pri	or to comp	y findings available eletion of cause of
a	a u	e Col	25. Was case referred to medical	CRYTHMIAS				performe 1 Yes 2	d? de	ath? JYes 2	No No
		0 8		ospital: 1  Inpatient 2 ER/C	Outpatient	3□ DOA Other	26. Place of Death	(Check only one) ne 5 ☐ Residen	o s Cothor	(Speciful	
n or	ding Phy h. After this funeral c	Du: T	27. Manner of Death  1 Natural 5 Pending	And the second s	Time of Injury	28c. Injury a Work?		8d. Describe how			
UIVISION		icat	2 Accident investigation 3 Suicide 6 Could not be	On Discontinue Athense		M 1 □ Ye	s 2 No				
2	al or Attenater deat I Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	arm, stree	et, factory, office	2	8f. Location (Stree City or Town,	at and Number State)	or Rural R	loute Number,
	e Hospital or / 24 hours after e Funeral Dire letely filled in b	edical C	Check only 21 Medical Examinin	cian: To the best of my knowledger: On the basis of examination a	je, death o	occurred at the time,	, date and place, a	nd due to the caused at the time, date	se(s) and mann	ner as state	ed.
	To the within 2 To the comple	Med	29b. Signature and title of certhier	and mariner stated.	2	29c. License r			. Date signed (		
	- s - ō		1 Such	(PHYSICI	Ani)		5782				h 2004
	2101		30. Name and address of person who com				D				
1.	Dis		Suresh Verges 31. Date filed (Month, Day, Year)		Li	vingston	Koad #10:	L Ft. Was	shington	n MD	20744-5104
	Sta	.e.	DEC 2 2 20	32. Registrar's Signature	4	all I					

			State of Maryland / Department / Department / Department / Department / Department / Department		ental Hygie	•
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last)  Philias Frank Heath  4a. Facility Name (If not institution, give street and number)	4.00 7	2. Date of Death Month DEC 2:	Day Year 3. Time of Death 1:00 A M
	Examir	ier	CIVISTA MEDICAL CENTER	4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES
	Funeral Director		5. Social Security Number  579-36-1983  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 16,	ear) 9. Birthplace (State or Foreign Country) Washington DC
	e Maryland ia-f show	ctor	10a. State 10b. County 10c. City, Town or Loc  Maryland Charles Waldorf	ation		10d. Inside City Limits 1 ☐ Yes 💥 No
	after death with the Maryland or Itams 23a or 28a-f show ment must be notified at	Dire	10e. Street and Number 7031 Evergreen Drive	10f. Zip Code 20601		Citizen of What Country?  Jnited States
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked othar than "natural; or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.	by Funerai	1 Never Married 2 N Married 1 N Yes 2 No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F ☐ Yes 2 X No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
215-06	hin 72 hou e. an "natura Medical E	Completed	1555-56	ent's Usual Occupation kind of work done during most of workin O NOT use retired)	ng 160	white b. Kind of Business/Industry
nd 21	be filed wit tal Hygiene d othar tha avant, the	Be Corr		trician  18. Mother's Name		EPCO iden Surname)
aryla	should I	L C	Frank M. Heath  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Yvonne N g Address (Street and Number or Rural		ity or Town, State, Zip Code)
Philias	ss 1 and 2 of Health s Itam 27 li		20a. Method of Disposition 20b. Place of Dispos	Evergreen Drive,		MD 20601 c. Location - City or Town, State
altimo	permit. Page Department i Important: II any injury or once.		'4 □Donation 5 □Other (Specify)  St. Mary 'S  21. Signature of Funeral Service Licensee M01391  22.	Cemetery 12-28 Name and Address of Facility		over, New Jersey
9	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	Huntt Funeral Home P.O. Box 156, Wale r the mode of dying, such as cardiac or 	respiratory arrest,	Interval Between
	ficate be execut physician and s the burial-tran	icai	resulting in death) Last  Due to (or as a consequence of):  d.			
P.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other <i>(specify)</i>		23d. Date of delivery Month Day Year
ırds, P	w requires that been signed to should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I.		co use contribute to the cause of death?
	The tay ate has page 2	Completed			24a. Was an autopsy performed 1 Yes 2	
Vita	sician: certific	o Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death	-	
ion of	nding Phys ath. r: After this e funeral di	-	1   Yes 2   No Hospital: Inpatient 2   ER/Outpatient  27. Manner of Death 1   Shatural 5   Pending 2   Accident investigation   Accident   Acci		e 5 ☐ Residence 8d. Describe how in	e 6 Other (Specify)  njury occurred
Divis	To the Hospital or Attanding Pl within 24 hours after death. To tha Funaral Director: After ti completely filled in by the funera	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	at, factory, office 28	8f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	ne Hospi n 24 hou ha Funar	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	occurred at the time, date and place, an stigation, in my opinion, death occurred	nd due to the cause d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	29c. License number D = 20629	29d.	Date signed (Month, Day, Year)
$N_t$	P/18+1			rint) 45 PEMBROOKE SQ	UARE WA	LDORF, MD 20603
	Sta Registr		31. Date filed (Month, Flar, Coan) 7 2004 32. Resistrar's Signature	books		

			For 1 State	State of Ma		nd / Depa		Health a	nd Mental Hy	giene 0	) 4 4	2375
			Registrar  1. Decedent's Name (First, Middle, Las			Cer	ilicale of	Dealli	2. Date of D	Reg. No.	- 2	Time of Death
	Physici /Medic		Frances Howard						DECEM DECEM	BER 30	2001	8 49m
	Examir	ner	4a. Fecility Name (If not institution, give		_ \ [	0	4b. City, Town, o			4c. County of		
	Funeral		5. Social Security Number 6. S	OXIVER 7. Age		last birthday)	If Under 1 Year	If Under 2	4 Hrs. S Date of Bi	rth	9. Birthplace	(State or Foreign
,	Funeral Director			□M 2 <b>2</b> F		)3 Yrs.	Months Days	Hours	May 18	3, Yel 911	Mary lar	(State or Foreign nd
	show		10a. State 10b. County	7	10c. Cit	ty, Town or Loc						nside City Limits
Q	the Ma	ctol	MD Harfo	rd		Aberde	≥n					Yes 2 No
4	들 하게	Funeral Director	10e. Street and Number 2214 Perryman R	oad			10f. Zip Code 2100	1		10g. Citizen of W	_	
3	er death w items 23a	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U	.S. 13. W	as Decedent of H Yes, specify Cub	lispanic Origi an, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race Black	- American Inc., White, etc.	dian,
5-0036	ours afte	1 by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:	10		☐ Yes 2☑ No			Specify:		
5-6	"natu	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Decede	ent's Usual Occup ind of work done O NOT use retired	during most	of working	16b. Kind of Bus	iness/Industry	1
212		ошо	Elementary/Secondary (0-12)	College (1-4or 5	+)	Manag		<i>a)</i>		Forest 6	reen's	Beach
ৈত> Maryland 2	ould be filed Mental Hygi arked other attic avent, I	To Be Completed by	17. Father's Name (First, Middle, Last) UNK						s Name (First, Middle JNK	, Maiden Surname	i)	
<i>CC</i> ≥ Mary	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (1 William Howard						or Rural Route Numb Aberdeen,			
2AA more,	Pages 1 a ent of He nt: If item ry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. F	Place of Dispos cemetery, crem esutia	ition (Name of atory or other plac Cemetery	<sub>се)</sub>	Date /4/05	20c. Location - 0	•	State
Balti	permit. Pag Department important: any injury o		21. Signature of Funeral Service Licen		)	22. T	Name and Addre	ss of Facility	langral 100	ne <sub>33</sub> 89 <sup>A</sup> .		
11K	Fhysician (Medical Examiner partial)	Examiner	23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as.  Due to (or as.	a conseq	uence of):	r the mode of dyir	A cold	ecut	irrest,	Inter	roximate rval Between et and Death
P.O. Box 68760	t the death certificate by the attending phy: ached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	ıl death 3 □	Ectopic pregnancy Other (specify)	у		23d. Date Mon	of delivery th Day	Year
Division of Vital Records, F	w requires that been signed is should be det	leted by F	Part II. Other significant conditions of	ontributing to death be	ut not res	sulting in the un	derlying cause giv	ven in Part I.	23e. Did	an 24b. W	3 ☐ Probably	4 Unknown
al Re	ician: The lav certificate has ector, page 2		- Cropharyns	ext 19	Sp	ngia			— auto	psy ormed? de	or to completi eath? Yes 2	ion of cause of
Vit	ysician: is certific director,	Be c	25. Was case referred to indical examiner?  1 Yes 2 No	Hospital:		JEB/0-1-1-1-1	out no.	100	of Death (Check only		(2)	-
on of	ding Phys h. After this funeral di	ion: To	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Injur Wor		28d. Describe	dence 6 Other	1 - 7 - 77	
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined		ury - At h	ome, farm, stre (y)			28f. Location	Street and Numbe wn, State)	r or Rural Rou	ite Number,
	Hospita 24 hours Funeral stely filled	Medical C		ysician: To the best of the basis of and manner sta	examina							
	ro the within Fo the comple	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed	(Month, Day,	Year)
	JF 0		Man	199			D. C	משוג		Doca - L	2 3	7204
	,		30. Name and address of person who	completed sause of d	eath (Iten	n 23a) (Type, 5	vint)	1389	1	renp	100)	LOUT
	5		Manuel M	LIZERE		MP	8	an St	ret X	bert eer	-17	entere
	Sta Registr		31. Date filed (Month, Day, Year)	05 32 Registra	ar's Signa	Mile.	de	- /			/110	

			For State Registrar	State of		/ Depa		t of H	ealth a	and M	lental Hyg	•	04	423	76
			Decedent's Name (First, Middle, Last	st)							2. Date of Deat	h		3. Time of	
	Physicia		Katheri	ne Anna	Halev						Decembe	r 30	2004	1441	$P^{M}$
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death		1	nty of Death		
1			Union Hospital				E1k	ton				Ced	cil		
	Funeral		Social Security Number     6. S	ex 7. □M 2 🗓 F	Age (In yrs. las	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State o	or Foreign
	Director	-	212-20-55/4	UM ZUALF	88	Yrs.					June 5,	1916	Del	aware	
	and •	-	Usual Residence of Decedent  10a, State 10b, County		10c. City,	Town or Lo	ocation							10d. Inside Ci	ity Limits
	Manyl f sho	6	Maryland Cecil		F1	kton								1 ∰Yes	2 No
	the 1	Funeral Director	10e. Street and Number		111	KCOII	10f. Zip	Code			1	og. Citizen o	of What Cou	ntry?	
	3a of	٥	243 East Main S	troot			21	921				Unit	ted St	atos	
	ms 2	Jera	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.			spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. R	ace - Ameri	can Indian,	
9	after or Ite	3	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 If Yes, Give			1 ⊡Yes 2		Specify:		rican, etc.)	Spec	lack, White,	etc.	
93	72 hours after death with the Maryland naturel', or liems 23a or 28e-f show lical Evaniner must be notified at	d b	3 ☐XWidowed 4 ☐ Divorced	Year or Date	es:		1 🗆 103 2	сдио	apoony.			Зрес		ite	
21215-0036	72 h natu	Completed by	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation <i>Juring mos</i>	t of work	ing	16b. Kind of	Business/In	dustry	
121	within ene. than *	m	Elementary/Secondary (0-12)	College (1-4	or 5+)		emake		,		1	In Hei	c Our	Ното	
2	Hygie Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Last)			HOP	emake	1	18. Mothe	er's Name	e (First, Middle, M			nome	
an	d be antai	o Be	Eben Columbo Al						Τ.,	anor:	a Virgin	ia Far	rige		
Maryland	2 shoul and Me Is mark eumeti	2	19a. Informant's Name/Relationship (			19b. Mailir	ng Address	(Street a			al Route Number,			Code)	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydione. Department of Health and Mental Hydione. Department of Health and Mental Hydione. Department of Hydione 21 is marked other than "naturel; or titems 23a or 28e-f show any injury or other treumette event, the Medical Examinat must be notified at 2006.		Virginia L. Harvi	11a/Daug	hter	320 E	ast V	i 11a	ee Ro	had.	Elkton.	Marv1	and 2	1921	
ē,	s 1 and I Head item other		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nan	ne of	-	- 1	ary 4,	20c. Location	n - City or To	own, State	
Ë	Page ient o nt: If ry or		1 ☐XBurial 2 ☐ Cremation 3 ☐  1 ☐ Cremation 3 ☐ Other (Specification 5		ate	-	Ceme			2005		Townse	end. D	elawar	·e
Baltimore,	permit, Page Department of Importent: If any injury or ance.		21. Signature of Funeral Service Licer	1500		- 27 H	Name an	d Addres			erals, P		-		
m	9 0 E 8 0		David S.	Hicks	<u>ک</u>	1	03 W.	Sto	cktor	Sti	eet. Ell	cton,	Mary1	and 219	921
	289		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the death.	Do not ent	er the mode	e of dying	g, such as	cardiac (	or respiratory arre	est,	100000	Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	Acu	te Myo		5 - 55 H		vecti	en.				Unkno	Death (4.0)
8	/Medical		resulting in death)	Due to (or	as a cons que	nce of):	Luc .	1	1000	V.,					- Con
	Examiner		Sequentially list conditions.	b M	cumor	na								Unkn Unkn	avy
7	p is	iner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a conseque	nas oth	J.	P	1.1.		ey Dis	<b>.</b> .	1.	7 ,	,
1 1	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseque		ich.	e r	com	ona	ey 110	coise		unkr	navy
760,	be ey	caiE													
687	es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	edic		_ d											
Box (	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. E	ate of delive	ery	
B	atter for u	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnar	h 2∏Fetald nt at time ol dea		∃Ectopic pro ∃Other (spo					V	Month	Day Y	Year
P.O.	the cachec	hysi	9 Unknown	9□ Unknow	m										
	s that med be e det	y P	Part II. Other significant conditions of	ontributing to deat	th but not result	ing in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use co	ntribute to t	he cause of de	eath?
ğ	w require been sig should b	edt	Lung Mass								1 🗹 Ye	s 2 No	3 🗆 Prot	ably 4 □U	Jnknown
Records,	aw requas been 2 should	Completed by									24a. Was ar		. Were auto	psy findings a mpletion of ca	available ause of
Ä	The ate he	Com									perform 1 ☐ Yes 2	ied?	death?	2 🗆 No	
Vital	Physiclan: The law this certificate has b ral director, page 2 s	Bec	25. Was case referred to medical examiner?							of Deatl	(Check only one	9)			
of V	Physiclan: this certific al director,	2	1 ☐ Yes 2 ☑No		atient 2 EF			-	4 🗆 140		me 5 Reside			y)	
n o		on:	27, Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury 2 Day Year) 2	8b. Time of Injury		8c. Injury Work			28d. Describe ho	w injury occi	urred		
Sio	Attandi death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Llainer Athena		M		/es 2 □ I		28f. Location (Str	oot and Nun	nhor or Pur	I Pauta Numi	hor
Division	or All after of Direction by	Certification:	4  Homicide determined	building	l Injury - At hom , etc. <i>(Specify)</i>	ie, iaim, su	eet, ractory	, onice			City or Town	State)	noor or ribre	ii riodie i diiii	D61,
	purs cours (		29a. Certifier 1 Certifying Ph	vsician: To the b	est of my knowl	edge, deatl	h occurred a	at the tim	e. date an	d place.	and due to the ca	use(s) and n	nanner as s	tated.	-
	To the Hospitel or Attanding within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examinatio	n and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time, da	te and place	, and due to	the cause(s)	)
	o th	Me	29b. Signature and title of certifier				29c	. License	number		29	d. Date sign	ed (Month,	Day, Year)	
			> Sadider	15 mb				000	<i>\$</i> 332	2		12.	30.	04.	
	.1		30. Name and address of person who $S \cdot S \cdot SACHDFV$	completed cause	of death (Item 2	(3a) (Type,	Print)	_			tan MD à				
	/1			111111111			510-1-	20		-4-16		// 27~/!			
	Sta	te	31. Date filed (Month, Day, Year)  JAN 1 0 2	32. <b>#</b> eg	istrar's Signatur		Saile	38	1 6	-ep	yan myo	(170()	•		

S	252		for State Registrer	State of Marylar		artment rtificate			nd Me		iene		42377
	Physici /Medic		1. Decedent's Name (First, Middle, Las Reginald A. Hayne						L	2. Date of Dea Month Decembe1	Day	, 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution, give Ft. Washington H	ospital		Fort	Was	Location of hingt	on			County of Death	Georges
	Funeral Director		5. Social Security Number 220-62-9103  Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Novermb	<sub>Year)</sub> l er 1	953 9. Birth Cou 3 Wash	place (State or Foreign intry) ington, DC
	e Maryland 3e-f show lifted at	ctor	MD Prince G		ty, Town or Lo								10d. Inside City Limits 1X Yes 2 □ No
	with th	Dire	10e. Street and Number 117 St. Andrews D:			10f. Zip C				1	_	zen of What Cou	intry?
036	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show folles! Examinar must be multified at	by Funeral Director	11. Marital Status  1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:				spanic Origin, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- lican, etc.)	1	USA 14. Race - Ameri Black, White Specify: B1a	, etc.
1215-0	⊆ 3 3	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	16a. Deced (Give life.	dent's Usual kind of work DO NOT use	doné di retired)	tion uring most	of workin	g		nd of Business/Ir	ndustry
Maryland 21215-0036	be filed ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, Last) Alex Haynes	2yrs		Plum				(First, Middle, I		ivate Sumame)	
ary	2 should by and Menta is marked aumatic e	ř	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (					; City or	Town, State, Zi	p Code)
Σ,	24年2		Louise D. Haynes/							. Washi			20744
Jore	0 0	1	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	removal nom State	Place of Dispo			1 -	Da 2/22			cation - City or T	
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify     21. Signature of Funeral Service Licen			. Name and	Address	of Facility	J.		cins	Funeral	Maryland l Home
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart dilure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the deal one cause on each line.  a. Due to (or as a consecutive co	Cerot	er the mode	of dying	1.		respiratory arro	est,	ease	Approximate Intervat Between Onset and Death
60,	death certificate be executed  e attending physician and  sof for use as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	quence ot):								
κ 68760,	artificate b fing physic e as the b	Medica	IF FEMALE:	d									
.O. Box	at the death certific by the attending p tached for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of 6 9 ☐ Unknown	aldeath 3□	Ectopic preg Other (spec					2	3d. Date of deliv Month	ery Day Year
ords, P	equires the	by	Part II. Other significant conditions co	entributing to death but not re-	sulting in the u	nderlying cau	ıse givei	n in Part I.				se contribute to t ☐No 3☐Prol	the cause of death?
of Vital Records,		Completed									n y ned? 2 🗆 No	24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of 2 No
Vita	Phyaician: T this certifical ral director, p	o Be	25. Was case referred to medical examiner?	Hospital:	leno		Other			(Check only on			
	ling After fune	$\vdash$	1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury Work	4 🗆 Nurs	28	e 5∐ Reside 3d. Describe ho		Other (Special occurred	(fy)
Division	in Dir	Certification;	3 Suicide 6 Could not be 4 Homicide determined	3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)									al Route Number,
	Hos Hos Fur tely	edicai		vsician: To the best of my kn iner: On the basis of examin- and manner stated.									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	M			License CME	number				ber 22,	
R	(3)		S. R. 1106	ompleted cause of death (Ite		Print)	Pen	ın Str	eet,	Baltin	nore	, MD 212	201
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 7 2004	39. Registrar's Sign		21							

			_ For	State of M		d / Depa	artment of H	ealth ar		_	_	101	10070
			Stete Registrar			Cei	rtificate of L	Death			g. No.	104	423/8
п	Physici	an	1. Decedent's Name (First, Middle, L		3 T 1713		10			Date of Death Month CEMBE:		2 <sup>Year</sup> 4	3. Time of Death
1	/Medic	al	IRIS ALEJANDRA			MIRAN		I continu of		CEMBE.			7:10 A M
	Examin	er	4a. Facility Name (If not institution, g				4b. City, Town, or		Death		4c. County		
			National Institu  5. Social Security Number 6.			last birthday)	Bethesd If Under 1 Year	a If Under 24	4 Hrs.   8. [	Date of Birth	Mon	g Sight	
	Funeral Director		None	1 □ M 2X0 F	16	Yrs.	Months Days	Hours	Min. (	Month, Day,		Hond	lace (State or Foreign try)
			Usual Residence of Decedent				J	!	Tite	iy 10 s	1700	iioiid	uras
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Limits
	a-f s	ctor	Honduras		Pu	erto C	ortes						1 ĀYes 2 ☐ No
	or 28	Olre	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	itry?
	ath w	ra	Res La Magdeler				None				Hondu		
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?	?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origi n, Mexican,	n? (Specify Puerto Rica	Yes or No- n, etc.)		ce - Americ ck, White,	
36	s afte	γF	1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		12XYes 2□No	Specify:	7 1		Specif		• .
응	72 hours after death with the Maryland natural', or items 23a or 28a-f show ileal Exacilinat fourthe natified at	Completed by Funeral Director	15. Decedent's			16a. Dece	dent's Usual Occupa	ation	Hondur		6b. Kind of B		ite dustry
15	in 72 n "na	plet	(Specify only highest g	rade completed)	5.1	(Give life.	kind of work done o DO NOT use retired	during most o	of working				,
212	d within jiene. r then "	Шo	Elementary/Secondary (0-12)	College (1-4or	<b>3+</b> )	Stud	ent				None	2	
Þ	e filed within al Hygiene. I other then " vant, II e Mo	Bec	17. Father's Name (First, Middle, La	st)				18. Mother's	s Name (Fil	st, Middle, M	aiden Sumar	me)	
<u>lar</u>	uld be Aental rked c tic eve	ToE	Gazar Hedman					Main	ra Alt	amiran	10		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, if a Modical Exertifier inset to notified at		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Number	o <i>r Rural R</i> o	ute Number,	City or Town	, State, Zip	Code)
_	is 1 and 2 of Health itam 27 i		Maira Altamirano	/Mother			La Magdal	ena I					
ore	of He of He fitan roth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from State		Place of Dispo semetery, crea	sition (Name of matory or other place	θ)	Date	2	0c. Location	- City or To	wn, State
Ĕ	Pag nent ant: f ury o		*4 □Donation 5 □ Other (Spec			Auxi1	iadora	12	-29-20	004 S	an Beu	iro Su	ıla, Hondura
Baltimore,	permit. Pages 1 a Department of He Important: If itam any injury or oth		21. Signature of Funeral Service Lic	ensee	10	22 M	Name and Addres	s of Facility	cal Ho	ma In	C		
	20529		J. P. 1/ F	ushal			arshall's 217 9th S					.C. 20	0011
			23a. Part1. Enter the disease, or co	mplications that cause ly one cause on each l	d the deat ine.	h. Do not ent	er the mode of dying	g, such as ca	ardiac or res	spiratory arres	st,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Lec	, kei	ui a						2	20 months.
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):							
	LAGITITICI	٠.	Sequentially list conditions,	bbue to (or as	2 000000	uanaa of):							
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	derice or).							
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):					7		
760,	that the death certificate be execu ed by the attending physician and detached for use as the burial-tra	calE		d									
.89	certificate Iding phy Ise as the		123	· · · · · · · · · · · · · · · · · · ·									
Вох	andin use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			∃Ectopic pregnancy				23d. Da	ite of delive	ry
	deatl e atte	icia	in the past 12 months? 1  Yes 2 No	4☐Pregnant a			Other (specify)				Mo	onth	Day Year
P.O.	requires that the een signed by th hould be detache	Completed by Physician/Med	9 ☐ Unknown										
	w requires that been signed to should be det	by	Part II. Dther significant conditions	contributing to death l	out not res	ulting in the u	nderlying cause give	en in Part I.					e cause of death? ably 4 □Unknown
ord	equir sen s noutd	ted					<del></del>		-	1 ☐ Yes	2 No	3   100	ably 4 DOTKHOWN
ec	aw as b	nple					<u>.</u>			24a. Was an autopsy		Were autor prior to cor death?	psy findings available apletion of cause of
E	ate pag	Co								perform 1 ☐ Yes 2			2 <b>X</b> /No
Vital Records,	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		-	othe Othe	25		eck only one			
of	<b>%</b> .∞ <del>.</del> ⊕	2	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Inpati		ER/Outpatier 28b. Time o	IL SU DOA	4   19015		5 Residen			"
O	ding h. After fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	ay Year)	Injury	Work	k? Yes 2 ⊡ No					
Division of	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	jury - At h	ome, larm, sti	reet, factory, office					ber or Rura	I Route Number,
ō	alor, after a after I Dire	Certification:	4 Homicide	building, e	tc. (Specif	<b>y</b> )				City or Town,	State)		
	pspita hours unera y fille	al	29a. Certifier 12 Certifying	Physician: To the best	of my kno	wiedge, deat	h occurred at the tim	ne, date and	place, and	due to the cau	use(s) and ma	anner as st	ated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner s	tated.	ition and/or in			occurred a				
	Vith.	Σ	29b. Signature and title of certifier	4 .	)		29c. License			29	d. Date signe	ed (Month, i	Day, Year)
			1/1/1/2	- IN			D61:	748			2/23/	04	
R	(1)		30. Name and address of person wh	1.0	death (Iter								
			31. Date filed (Month, Day, Year)	A	rar's Signa		CENTER D	RIVE	BETH	ESDA,	MD 2	0892	
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 7 200		. A	die	3.9						
	3			And the same	-	1							

Sh RJ	aunti J D	lac	KSON  For State Registrar		State of	Marylar	-	artmen rtificat				lental Hy	giene	nn.	. 423	19
	a		Decedent's Name (First, Name)	liddle, Last)								2. Date of De	ath		3. Time of D	eath
	Physici /Medic		Shaunti		Jacks							Detemb	er 24	0, 200	4 1920 P	• м
	Examin		4a. Facility Name (If not instit 6136 Surrey			nber)		Forr	estv					county of D	eath eorges	
	Funeral Director		5. Social Security Number 215-94-9729 Usual Residence of Deceder		k M 2□F	7. Age (In yrs. 25	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		Birthplace (State or I Country) shington,	
	Maryland a-f show	tor	10a. State 10b. Co	unty	eorges		ty, Town or Lo yattsv			<del></del>					10d. Inside City 1 √ Yes 2	
	th with the 23a or 28	ai Dire	10e. Street and Number 1523 Ray Roa	ıd #20	2			10f. Zip	Code 782				•	izen of What JSA	Country?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-1 show any injury or other traumatic avant, If a Medical Evander must be notified at 200e.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2☐ 3 ☐ Widowed 4 ☐ Divo	Married	12. Was Dece Armed For 1Yes If Yes, Giv Year or Da	ces? 2 🔯 No e		Was Deceo If Yes, spec 1 ☐ Yes		ispanic Or in, Mexica Specity:		ecify Yes or No Rican, etc.)	>-		merican Indian, /hite, etc. Black	
21215-0036	within 72 ho ane. than "natur	Completed	(Specify only h Elementary/Secondary (0-			-4or 5+)	(Give	dent's Usua kind of wo DO NOT us Iter ]	rk done i se retired	during mos i)		ing	16b. K	ind of Busine		
	filled Hygie other		12th. 17. Father's Name (First, Mic	Idle, Last)								e (First, Middle	, Maiden			
Maryland	should be ind Mental s marked o umatic ava	To Be	Garrett Jack		pe. Print)		19b. Maili	na Address	(Street			Abbott al Route Numb		r Town, State	e. Zip Code)	
<b>≥</b>	and 2 sealth an n 27 ls		Beverly A. As					•	,			ttsvill				
Baltimore,	Pages 1 ar nent of Hea int: If item i	8	20a. Method of Disposition  1 Burial 2 Crema 4 Donation 5 Oth	ion 3 🗆 F		State	Place of Dispo cemetery, cre	osition (Nar. matory or o	ne of ther plac	(e)	-2-6	Date	20c. Lo	ocation - City	or Town, State	
Baltir	permit. P Departme Importan any injur.		21. Signature of Funeral Ser		90 1 la a	OD ,		2. Name an	d Addre	ss of Facili	<sup>ity</sup> Mar	9-04 shall's Washing	Fun	eral H	lome	
			23a. Part1 Enter the diseas shock, or heart failure.	e, or compli	ications that cane cause on ea	aused the dea								-	Approximate Interval Between	en
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		a_au	OSNO or as a conse	st u	Dur	nd	05	he	ed			Onset and De	ath
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	Due to (	or as a conse	quence of):									
8760,	icate be executed physician and s the burial-transit	dical Exa	resulting in death) Last	U	Due to (	or as a conse	quence of):									,
P.O. Box 6	ie death certif the attending hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t 2		irth 2 ∏Fet ant at time of	al death 3	]Ectopic pr ] Other (sp						23d. Date of Month	delivery Day Ye	ear
	w requires that the been signed by should be detacl	ed by Pr	Part II. Other significant con	nditions cor	ntributing to de	eath but not re	sutting in the u	nderlying c	ause giv	en in Part	l,	23e. Did 1		_/	e to the cause of dea	
Records,	The law re ate has bee page 2 sho	Completed by		-								24a. Was auto perfe		24b. Were prior death		vailable use of
ita	i <b>ician:</b> Th certificate rector, pag	Be C	25. Was case referred to me examiner?								e of Deat	h (Check only	on <i>e)</i>			
of V	Physician: r this certific ral director,	ို	1 X Yes 2 No	1			ER/Outpatie			4 🔲 🖂	ursing Ho	ome 5 Resi		6 Other (S	ipecify) (scen	e)
Division of Vital	Attanding F r death. ector: After by the funera	ation:	2 [] / 100100111	ending vestigation ould not be	28a. Date of	n, Day Year)	28b. Time of Injury	6 PM	28c. Injur Wor 1 🔲		(No	SUL SUL	S) & (	t 5	hot	
DİVİ	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director.	Certification:	4 Homicide de	termined	buildir	ng, etc. (Spec	cas					6136	wn, State	LT PH	Rural Route Number	
	To tha Hospital or within 24 hours afte To the Funaral Directory completely filled in h	Medical	(Check only 2 X Med one)	ical Exami		asis of examin		vestigation	, in my o	pinion, dea		and due to the red at the time,	date and	place, and	due to the cause(s)	
13	Tot com	Σ	29b. Signature and title of ce	ertifier	a.	Po	llel.	290 O	. C.M.	e number [.E.		]			1, 2004	
1	(5)		30. Name and address of pe	rson who co	ompleted caus	e of death (Ite	m 23a) (Type	Print) 11	1 Pe	nn St	t., F	Baltimon	ce, N	Maryla	nd 21201	

State Registrar

DEC 2 8 2004

31. Date filed (Month, Day, Year)

			For State Registrar		State of Ma	ıryland /	Depa Cer	artment of F rtificate of	lealth a <i>Death</i>	and Mental	Hygier Reg. 1		42380
<b>16</b>	Physicia	an	1. Decedent's Name	•	st)					2. Date of Month	of Death	Ži 2004	3. Time of Death
	/Medic	al	WALTER  4a. Facility Name (#	JOHNSON not institution, give	street and number)			4b. City, Town, o	r Location of			4c. County of De	
	LXaiiiii	C1	Southern	Mary1and	Hospital			Clint		2411		rince G	
	Funeral Director		5. Social Security Nu 148–26–606	1	ex	69	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. July	15°19	35 Pe	Birthplace (State or Foreign Country) nnsylvania
-	and wc		Usual Residence of I			10c. City, To	own or Lo	cation					10d. Inside City Limits
	e-f sho	ctor	Mary1and	Charles			Wal	dorf					Y☐Yes 2☐No
	with the	Directo	10e. Street and Num					10f. Zip Code 2060	11		10g.	Citizen of What USA	
	death ms 234	Funeral	5113 A1fr	red Drive	12 Was Decedent F	ever in U.S.	13. \	Was Decedent of H		gin? (Specify Yes	or No-	14. Race - A	merican Indian,
2-003p	be filed within 72 hours after death with the Maryland tid Hyglene. And the Waller than "natural", or Items 23a or 28e-f show of other than "natural", or Items 23a or 28e-f show event. The Medical Examinar must be incitified at	by	Never Marrie 3 ☐ Widowed 4		Armed Forces? 1X Yes 2 □ N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2 ☐XNo	Specify:	, Puerto Hican, etc	:-)	Specify: B	
<u></u>	n 72 h	etec	(Specit	15. Decedent's Ed fy only highest gra	lucation de <i>completed)</i>	16	(Give	dent's Usual Occup kind of work done DO NDT use retired	durina most	of working	16b.	Kind of Busine	ss/Industry
717	er than "c	Completed	Elementary/Secon	idary (0-12)	College (1-4or 5	+)		ntenance			R	efuse I	ndustry
yland	ould be filed Mental Hygi arkad other atic evant.	Be	17. Father's Name (F							r's Name <i>(First, M</i> . lian Joh		en Sumame)	
Mary	S D E E	2	19a. Informant's Nar	me/Relationship (7				ng Address (Street					
	s 1 and 2 of Heelth a item 27 is other tree		Linda G. C		Sister in			Alfred I	rive	Waldorf,	-	land 20	
altimore,			1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation 3 ☐ 5 ☐ Other (Specify		ceme	poli	tan Crema	atory	12-23-04	202		
gan	permit. Page Depertment of Importent; if any injury or once.		21. Signature o Fun	ne al Service Licen	lu MOO1	73	-	Name and Addre		FDGT MGT			
					plications that caused one cause on each lin			er the mode of dyin	ng, such as o	cardiac or respirate	ory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical	V 1	Immedate Cause (F disease or condition resulting in death)	-inai	aDue to (or as:	tho ma	_	ring .					
	Examiner		Sequentially list con	ditions,	b. =								
	uted d ansit	Examiner	Sequentially list con if any, leading to impresses. Enter Under Cause, Dispassion in that initiated events.	mediate lying njury	Due to (or as a	a consequenc	CB OT):						
Ď,	icate be executed physician and s the burial-transi		resulting in death) La	ast	Due to (or as a	consequenc	ce of):		-				
08/PO	ificate be executed g physician and ss the burial-transit	edlcal			. d								
Xog	death certi e attending id for use a	an/Me	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1 ☐ Live birth		ath 3□	Ectopic pregnancy	,			23d. Date of o	
j j	w requires that the death certif been signed by the attending should be detached for use a:	Physiclan/M	in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death		Other (specify)				Month	Day Year
ຸດ ກຸ	law requires that the as been signed by thi 2 should be detache	by Ph	Λ	cant conditions of	ontributing to death bu	ıt not resulting	g in the u	nderlying cause giv	en in Part I.				to the cause of death?
ora	requir	eted	Acquire	X 110-007(8)	defraction Syn	Mm					1 ☐ Yes Wasan		Probably 4 □Unknown
Vital Records,	sicien: The law certificate has l irector, page 2 s	ompleted							-		vves an autopsy performed' 'es 2 4	prior t death	autopsy findings available o completion of cause of ? es 22 No
/Ital	cien: ertifica ector, p	BeC	25. Was case referre	ed to medical	- Unanitali					of Death (Check of	nly one)		
0	y Physi er this c eral dir	n: To	1 ☐ Yes 2 ☑ 1 27. Manner of Death		28a. Date of Injur	nt 2 2 ER/0	. Time of		4 🗀 1401	rsing Home 5 28d. Desc		6 ☐Other (S)	pecify)
DIVISION	eath. or: Afte	catlo	1 ☑Natural 2 ☐ Accident	5 Pending investigation 6 Could not be			Injury	M 1 🗆	k? Yes 2 □ N				
Š	af or Att after d Direct of in by	Certification:	3 🖺 Suicide 4 🔲 Homicide	determined	28e. Place of Inju- building, etc	iry - At home, :. (Specify)	, farm, str	eet, factory, office			ion (Street r Town, St		Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	edical C			ysician: To the best on the basis of and manner sta	examination							
	To the within To the comple	Med		tle of certifier	and manner sta			29c. Licens			29d. [	Date signed (Mo	nth, Day, Year)
			► K/2	h	My				0551	120	De	( 21 Ze	104
1	Ъ		30. Name and addre	wellature	completed cause of di	oath (Item 23)	a) (Type. Accou	m SE Sun	te 310	Washing	Wn Do	20032	
	Sta Registr		31. Date filed (Monti	h, Day, Year) DEC 2 3 2	2004 32. Registra	ar's Signatur	1. 19	parle		1			
			L	, L 0 N 0 .	400								

			For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of He		nd Mental	Hygien Reg. W	11 63	42381
			Decedent's Name (First, Middle, I	_ast)				2. Date of	f Death		3. Time of Death
	Physici /Medic		LYNDA SUE JER	EW				Dece	mber :		4 1:23 P M
	Examin		4a. Facility Name (If not institution, g		r)	4b. City, Town, or I		Death	-	c. County of De	ath
	Funeral Director		251-88-2041	.Sex 7.7 1 □ M 21X F	Age (In yrs. last birthday 57 Yrs.	Months Days	Hours		i, Day, Yeai	7) (	irthplace (State or Foreign Country) 1ifornia
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mary Be-1 sh	tor	Maryland Charle	5	Waldorf						Yes 2 □ No
	3a or 28	I Director	10e. Street and Number 11735 Torcello	Court		10f. Zip Code 2060	01		10g. C	itizen of What (	Country?
980	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show official Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1	]No	Was Decedent of His If Yes, specify Cuban	panic Orig , Mexican, Specify:	in? (Specify Yes of Puerto Rican, etc	or No-	14. Race - An Black, Wh Specify: W	
2-0	72	eted	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occupat e kind of work done du	ring most	of working	16b. I	Kind of Busines	s/Industry
2121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4o	ir 5+) life.	DO NOT use retired) sewife	3	3	O	wn Home	
Maryland 21215-0036	0 20 0	To Be C	17. Father's Name (First, Middle, La Cleon Freeze	st)				's Name (First, Mi Freeze	ddle, Maide	n Sumame)	
aryl	should and Men s marke	F	19a. Informant's Name/Relationship	(Type, Print)		ling Address (Street ar					, Zip Code)
			David H. Jerew (	Husband)		35 Torcello	o Cou				
lore	Ø1 4		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			ematory or other place		Date		Location - City o	
Baltimore,	permit. Page Department of Important: if any injury or once.		4 □ Donation 5 □ other (Special Signature of Funder t Service Line	ense		itan Crema: 22. Name and Address				exandri exal So	
Ba	permit. Departr Imports any inji		VIJAN 15	MO	ULIU	4433 White					
	72 TH		23a. P.m1. Enter the disease, or conditions, or heart failure. List or	implications that caus by one cause on each	ed the death. Do not er						Approximate Interval Between
	Pnysician		Impediate Cause (Final dilease or condition sutting in death)	_a_ Seve	ce Emphys	ema					Onset and Death
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	蜡	Je.	Sequentially list conditions, if any, leading to immediate	b. Chroi	ic obstri	uctive P	Lumoi	nary Di	sease	3	
	cuted nd transit	Examiner	if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	с.							
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or a	as a consequence of):						
687	icate t physics the t	dical		d.							
O. Box (	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			-	23d. Date of d Month	elivery Day Year
ds, P.	as gn	by	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause give	n in Part I.		Did tobacco		to the cause of death?  Probably 4 □Unknown
Record	e law has b	Completed							Was an autopsy performed? 'es 2↓ N	prior to death	autopsy findings available ocompletion of cause
Vital		Bec	25. Was case referred to medical examiner?			_		of Death (Check of	-A-		
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ☐ XNo		atient 2 ER/Outpatie	4	4 🗀 1901	sing Home 5			pecify)
	ing After une	lon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Ir (Month, I	njury 28b. Time Day Year) lnjury	Work'	at ? es 2 □ N		ribe how inj	ury occurred	
Division	or Atten fter deati Director: in by the	Certification:	2 Accident 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of	tnjury - At home, tarm, s etc. (Specify)			28f. Locat	on (Street a r Town, Sta		Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical Co			st of my knowledge, dea s of examination and/or i stated.						
	To the within To the Comple	Me	29b. Signature and title of confitier	7 /		29c. License	number			ate signed (Mo	
			· Coll	Will		- D-469	79		Dec	ember	27, 2004
M	P 8		30. Name and address of person & Collins P. Sein,				te 20	)3A, Wald	lorf,	MD 2060	2
IA (	Sta		31. Date filed (Month, Day, Year) DEC 2	7 2004 32. Reg	trar's Signature	Sec. V.					
	Regist	rair	223 2		NOW YOU	Market .					

			1 - For State Registrar			Marylar		artment of rtificate of			Reg	ne . No. 201	)4	42383
	Physici /Medic		1. Decedent's Name (First, Ruth	Aiddle, Last,		Kirby				Dec	Date of Death Month ember	ੀ,20°	0°4	3. Time of Death 7:19P M
	Examin		4a. Facility Name (If not inst 13340 Bude						rlott	e Hal		4c. County of Char	:les	
	Funeral Director		5. Social Security Number 577 – 38 – 0796		х ] м 2 <b>Х</b> Т	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. 8. Min. Ju	Date of Birth Month, Bay, Y INE 24,	<b>1</b> 927	D. Birthpl Coun	ace (State or Foreign
	Maryland f show	tor	Usual Residence of Deceder 10a. State 10b. C		es		y, Town or Lo	cation tte Ha	11				10	0d. fnside City Limits
	with the	Funeral Director	10e. Street and Number 13340 Budo	s Cr	eek Ro	ad		10f. Zip Code	20622	-	10g	. Citizen of Wh	at Coun	try?
920	72 hours after death with the Maryland natural', or items 23a or 28a-1 show ucal Exacitied at	by	11. Marital Status  1 □ Never Married 2 □  3 ☑ Widowed 4 □ Div	1	12. Was Dece Armed For 1 Tyes If Yes, Giv Year or Da	2X No		Was Decedent of f Yes, specify Cu			y Yes or No- ean, etc.)	14. Race - Black, Specify:	White, 6	
21215-0036	within ene. than "	Completed	15. De (Specify only Elementary/Secondary (0			-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use retii rator	e durina mos	st of working	16	b. Kind of Busi		,
Maryland 3	uld be filed Aental Hygi rkad othar tic avant, t	To Be C	17. Father's Name (First, M James Mullh		n						First, Middle, Ma. Mullha			
	and 2 should halth and Men 127 is marks ar traumatic		19a. Informant's Name/Rel					ng Address <i>(Stree</i>						<sup>Code)</sup> 20622 all,MD
Baltimore,	Pages 1 annout of He ant: If itan		20a. Method of Disposition			State Tr	emetery, cres inity	sition (Name of matory or other p Memor:	ial G	ar.12		c. Location - Ci Wald		
Balt	permit. Pag Department Important: h any injury o		21. Signatur Funeral Se		Shall	мо <del>о</del> 94 /	2.0	Name and Add AREHAR'	Γ-ECH	OLS F				
	Physician		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition	e, or comp List only o	ne cause on e	ach line.		er the mode of d						proximate Interval Between Onset and Death 7 MOXLYNS
	/Medical Examiner	_	resulting in death)  Sequentially list conditions.		b	or as a consec								
8760,	ate be executed hysician and the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c	or as a consec								
P.O. Box 68	death certific e attending p od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	11.		irth 2∏ Feta ant at time of c	II death 3	Ectopic pregnan	су	***		23d. Date of Month		ry Day Year
	Se 75 90	by	Part II. Other significant co	nditions co	ntributing to de	ath but not res	ulting in the u	nderlying cause o	iven in Part	l.				e cause of death?
al Records,	The ate h	Completed									24a. Was an autopsy performs	d? prid	or to com th?	osy findings available of 2 No
on of Vital	Attanding Physician: Thrideath. actor: Atter this certificate by the funeral director, pag	tion: To Be		-		npatient 2 [ of Injury h, Day Year)	ER/Outpatier 28b. Time or Injury	28c. Inj	ther: 4 N	ursing Home 28d	Residence  Describe how			1
Division	al or Attan safter death Diractor: d in by the	Certification:	3 ☐ Suicide 6 ☐ 0	ould not be etermined		of fnjury - At h ig, etc. <i>(Speci</i> i		eet, factory, office	9	28f.	Location (Stree City or Town, S		or Rural	Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edical C				sis of examina		n occurred at the vestigation, in my						
)	To the within 2 To the complet	Me	29b. Signature and title of c	entifier					ob 9	9		Date signed (		* .
0	B7		30. Name and address of p	5	0121	man	A -7	an 25	Three	. MTH	HRUAD	, HOUL	1 Wat	D.MD
	Sta Registi	- 1	31. Date filed (Month, Day,	(ear)	32. R	egistrar's Signa	ture &	porte						

Amend Item Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1- State
Registrar Amended 12-27-04 item #8/wi@ratificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 6:17 PM DENISE 12 JOSEPHINE 15 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner PENINSULA REGIONAL WICOMICE MEDICAL ENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 € F 199-50-1596 Usual Residence of Decedent Yrs. 8 Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Mcdical Examinar must be inclified at 1. Yes 2 □ No Director WICOMICO MD LISBUR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901-1 SA DOTH Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ∏Yes 2,5™No fYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. BLACK þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KHOL SALESPERSON [1 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any many or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HNN SCHOOLFIELD DORSE E 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) SAUSBURY 401-H-BOOTH ~ MOTHER 21801 H. HAL 37. IIID. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/31/04 Surial 2 Oremation 3 Removal from State POCOMOKE 4 □ Donation 5 □ Other (Specify) UNIONVILLE ( EMETARY BENNIE 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility SMITH ISABELL 0 PALISBURY 23a. Part. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cluse on each line. Approximate Interval Between Immediate Cause Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Decare or highly that initiated events Due to (or as a cor Examiner nce of the attending physician and ched for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a co seguence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 SANO 3 Probably 4 Unknown 1 Yes plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 1 ☐ Yes 2 Z No 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this filled in by the funeral 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct 4 | Homicide 15 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 13405. Division St. #301 Kazi S. Khan Salisbury, Md 21804 J.M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MFC 2 3 2004 Registrar

				1 _ State	State of Ma	aryland /		ment of H		ınd Me		9	nnı.	1.22	OF
				Registrar  1. Decedent's Name (First, Middle, Last)			Cerui	icale of i	Deam	2	Date of Dea	Reg. No	004	3. Time of	CO
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		- Funeral		5. Social Security Number 6. Sex		e (In yrs. last	t birthday)	Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birt (Month, Da 11/5/	h	9. Birth	place (State o	r Foreign
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-	36	il', or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	.0	1□	Yes 2 No	Specify:			S	Specify:	White	
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	Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show or other traumatic event, the Wedical Examinar must be notified at	Ţ	Joseph W  19a. Informant's Name/Relationship (Type	illiam		Lowe	Address (Stanst		rald		- Cit	Vande Town, State, Zij		
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-		-		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused	the death. (						-		Approximate Interval Bets	)
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	4	/Medical		disease or condition resulting in death)	Due to (or as			JA TOUR	,	•					
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5	Вох	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	lc. If yes, outcome							23	d. Date of deliv	ery	
	œ.	death e atte	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			topic pregnancy ther (s <i>pecify</i> )	<i>'</i>				Month	Day Y	'ear
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	S, F	es tha igned be de	by F	Part II. Other significant conditions con	nbuting to death b	ut not resultir	ng in the unde	rlying cause giv	en in Part I.				e contribute to t		
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	isi	death. ctor: A y the fu	flca	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home	e, farm, street				Location (S	Street and	Number or Rur	al Route Num	ber,
0	Div	offer effer Dire	Certification;	4 Homicide	building, et	c. (Specify)					City or Tov	vn, State)			
3		Hospital or Attending 24 hours efter death. Funeral Director: Aftentely filled in by the fune		29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin	ician: To the best	of my knowle	edge, death o	courred at the tir	ne, date and	d place, and	d due to the	cause(s) a	nd manner as s	stated.	
9		To the Hospital or Atteno within 24 hours effer death To the Funeral Director: completely filled in by the	Medical	one)	and manner st				·						
		With To To To To To To To To To To To To To	2	29b. Signature and title of pertifier				29c. Licens	t 1	2			signed (Month,	Day, rear)	1
•						(A)	201/77 - 51	P -	751	/		Nece	unber 3	1,20	10 4
		8		30 Mine and address of person who con	un 5.	70 nl	pper	cherche	ale	Pri	re i	suit	e 201	Bel	Air
		Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 1 0 2005	2. Registr	ar's Signature	Cosel	وع				MD	5/01	4	

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		State of Maryland	/ Department of Health and Me	211111 1.2386
· ·		Registrar Amend# 1. Per Phys. PGC	Certificate of Death	Reg. Not. UU ? ? UU 2. Date of Death 3. Time of Death
Physici	an	1. Decedent's Name (First, Middle, Last) Central Vent	ura Rivas Lenus	Month Day Year JODAM
/Media		4a. Facility Name (If not institution, give street and nymber)	4b. City, Town, or Location of Death	4c. County of Death
Examir	ier	Mines Georges Hospita	1 Cheve-11	At 1500 60010
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 His. 8 Months Days Hours Min.	B. Date of Birth 9. Birthplece (State or Foreign
Director		n/a 1\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		May 8, 1963 El Salvador
p >		Usual Residence of Decedent  10a. State 10b. County 10c. City, 7	Town or Location	10d. Inside City Limits
shor	5		Washington	1 <b>X</b> ) Yes 2 ☐ No
the N 28a-f	Director	District of Columbia	10f. Zip Code	10g. Citizen of What Country? Central
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death ms 2	Funerai	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri	
or Ite	Ē	1 X Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X No 1 Yes, 2 ive		
5-0036 72 hours at natural; or	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Jaiva	idol lan
2 2 8	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
d 2121 filed within Hygiene. ther than ont, Ins.Ma	m	Elementary/Secondary (0·12) College (1-4or 5+)	Construction Worker	Construction
Hygie other	S	17. Father's Name (First, Middle, Last)	18. Mother's Name (	(First, Middle, Maiden Sumame)
e d is b	To Be	Gustavo Lemus	Paula	Rivas
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic event	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code)
_ c = ~ L		Jose Ramos (Son)	14424 Filarete Street;	Woodbridge, Virginia 22193
altimore, rmit. Pages 1 ar partment of Hea portant: If Item y injury or othe		Edu. Hidriod of Bioposition	ce of Disposition (Name of Da netery, crematory or other place)	20c. Location - City of Town, State San Miguel,
Pages nent of I		1  Burial 2 □ Cremation 3 □ Removal from State  • 4 □ Donation 5 □ Other (Specify) San	Miguel Cemetery Dec.3	1,2004 El Salvador
Baltimol permit. Pages Department of Important: If It any injury or of		21. Signature of Funeral Servica Licenses	22 Name and Address of Facility Santa Cruz Funerari	os Servicios
<b>n</b> 88558		* Kamana Curm	600 Kennedy Street,	N.W.; Washington, D.C. 20011
		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or	respiratory arrest, Approximate Interval Between Onset and Death
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ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	A Lasin Hen	ourchese
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of Vital Records, P.O. Box 687 Physicien: The law requires that the death certificate rthis certificate has been signed by the attending physical director, page 2 should be detached for use as the	by Physician/Medic	u.		
BOX (leath certification)	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnance		23d. Date of delivery
Geath death d for	icia	in the past 12 months?  1  Yes 2 No		Month Day Year
P.O.	hys	9 Unknown		
IS, P.O. I res that the de signed by the a be detached f	by P	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
w require	ted	Respiratory Paris	116	1 Yes 2 No 3 Probably 4 Unknown
law ras be	pie			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
The The page	Completed			performed? death?  1 Yes 2 No 1 Yes 2 No
Division of Vital Records, at or Attending Physicien: The law requires the death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
of v	ုင			e 5 Residence 6 Other (Specify)
Ing F	on	1 Natural 5 Pending (Month, Day Year)	28c. Injury at   28c.	8d. Describe how injury occurred
Vision Attending or death. ector: After by the fune	icat	3 Suicide 6 Could not be 380 Place of Injury - Al hom		8f. Location (Street and Number or Rural Route Number,
Div A	Certification:	4 Homicide determined building, etc. (Specify)	STREET	City of Town, State)
Division of Vital Rec no the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2		29a. Certifier 1 Certifying Physicien: To the best of my knowl	ledge, death occurred at the time, date and place, and	nd due to the cause sand manner as stated.
ne Ho 7 24 P ne Fur iletely	Medical	(Check only one)  2 Medical Exeminer: On the basis of examination and manner stated.	on and/or investigation, in my opinion, death occurred	d at the time, date and place, and due to the cause(s)
To th within To th	ž	29b. Signature and life of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		1 SUN SOLA	1053650	1000 11 200 4
2 (2)		30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)	
		STEFFIEN SCHWARTZ 3001 HOSPITA		0 20185
	tate	31. Date filed (Month, Day, Year) DEC 2 7 2004	Should !	
Regis	ırar	DEO 4 4 Juliano Ju	7	

Jeanette Lee 04-8460 AKG

+ <b>-</b> 04	+60		1 - For Unpend 3	tem 2	23a,27,28a	aryland -f <b>pe</b> r	Dep Ce	artment of 6840 205 rtificate of	Healt f Dea	h and M tas th	fental Hy	giene Reg. No.		
	Physici /Medic		1. Decedent's Name (First, Jeanet		Lee						2. Date of De Month Decemb	per 3	31, 2004	
	Examin		4a. Fecility Name (If not inst 815 Thayer Av		street and number, #1636			4b. City, Town, Silver					ntgomer	
d	Funeral Director		5. Social Security Number 579–68–6002		ex 7. Ag ☐ M 2 1 F	ge (In yrs. Iasi 66	t birthday) Yrs.	If Under 1 Yea Months Day:		irs Min	8. Date of Bi (Month, Da Oct.15,	rth ay, Year) 193	Col	nplace (State or Foreign intry) Africa ra Leon,
	aryland show	l.a	Usual Residence of Deceder  10a. State 10b. C	ounty		10c. City, T								10d. Inside City Limits
	death with the Maryland ms 23e or 28e-f ehow	recto	Maryland Mor	tgome	ery	511	ver	Springs 101. Zip Code				10g. Citi:	zen of What Co	tx☐Yes 2☐No untry?
	th with 23e or	al Di	815 Thayer A	ve.				209	10			Uni	ited Sta	ites
920	after or Ite	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 █ Div		12. Was Decedent Armed Forces:  1  Yes 2 If Yes, Give Year or Dates:	?		Was Decedent of If Yes, specify Cu 1 X Yes 2 □ N			ecify Yes or Ne Rican, etc.)		14. Race - Amer Black, White Specify: B1	
21215-0036	within 72 hours ene. then "naturel", ne Medicel Ex-	Completed	(Specify only Elementary/Secondary (0		ducation de completed) College (1-4or		life.	dent's Usual Occ kind of work don DO NOT use retii	red)	most of work	ing		nd of Business/I	ndustry
	filed v Hygie other t	a)	12 17. Father's Name (First, M	ddle, Last)			S	eamstres		other's Name	e (First, Middle		rivate Sumame)	
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "Ireumetic event, the Mes	To B	Unknown						G	Bonu S	Sombi			
/Jan	l 2 sho and I is me reume		19a. Informant's Name/Rela					ng Address (Stree						
	Health Health tem 27 other tr	1	Maynetta Le	e /	Daughter			Thayer A sition (Name of matory or other p			Silver		cation - City or T	
ē	Pages tent of int: If i		1 ∰ Burial 2 □ Crema 1 4 □ Donation 5 □ Otl			'		natory or other pi Heaven	iace)	Jan. 7	,2005	Silv	ver Spri	ng. Md.
Baltimore,	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other 2008.		21. Signature of Funeral Se	rvicelicen	ver MO	185	-	2. Name and Add	ress of F	acility			nes, P.A	
		3:	23a. Parti. Enter the disea shock, or heart failure	se, or com List only	plications that cause one cause on each	d the death, I	Do not en	er the mode of d	ying, such	h as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a. Amiodi			cation						
	Examiner			- [	Due to (or as	a consequen	100 01):							
	p #	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or as	a consequen	ies of):							
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	1	c. Due to (or as	a consequen	nce of):						-	
68760,	icate be execu physician and s the burial-tra	dical		l	d									
_	artificate ing phys e as the	0	IF FEMALE:											
.O. Box	requires that the death certific een signed by the attending p hould be detached for use as:	Physician/M	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	ath 3[	Ectopic pregnan Other (specify)	су			2	23d. Date of deli- Month	very Day Year
<u>α</u>	res that signed b	by Pl	Part II. Other significant co	nditions o	ontributing to death	but not resultin	ng in the u	nderlying cause (	given in P	Part I.				the cause of death?
ecords,	w require been si should I						<del></del>					Yes 2[		
$\Xi$	The law ate has b page 2 sl	Completed	<u> </u>								1 Yes	psy ormed? 2 \Begin{align*} No	24b. Were aut prior to co death? 1 1 Yes	opsy findings available ompletion of cause of
of Vital	ysicien: ] is certifical director, p	o Be	25. Was case referred to mexaminer?	adical	Hospital: 1 ☐ Inpat	ent 2□ER	/Outpatie	nt 3 DOA	than		h <i>(Check only</i> me 5 ☐ Resi		S TrOther (Spec	ity) at scene
ion of	ding Ph h. After th funeral	ation; T	27. Manner of Death  1 Natural 5 F 2 Accident	ending evestigation	28a. Date of Inj (Month, Date of Inj 12-29-0	ury 28 ay Year)	Bb. Time of Injury	f unk 28c. Inj		_				prescription
Division	Diff	Certificat		ould not be letermined	286. Place of in	jury - At home tc. <i>(Specify)</i>	e, farm, st	reet, factory, office	е		28f. Location ( City or To Silver	wn, State)	815 The	al Route Number, nyer Ave.
	he Hospitel in 24 hours t he Funerel pletely filled	Medical	29a. Certifier 1 Ce (Check only 2 Me one)	rtifying Ph dical Exar	nysician: To the bes niner: On the basis and manner s	of examination	edge, deat n and/or in	h occurred at the vestigation, in my	time, date opinion,	te and place, death occurr	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of	antifier	- Rac	يه سار	>	29c. Lice		ber			e signed <i>(Month</i> mber 31 .	
e_	0		30. Name and address of p	No:	151-151	death (Item 23	2111	Penn St	reet	, Balt				1201
	Sta Regist		31. Date filed (Month, Day,		32. Regist	rar's Signatur	for	W						

Birthplace (State or Foreign Country)

10d. Inside City Limits

1⊠Yes 2 No

FLORTDA

3:21P M

nding physician Division of Vital Records, P.O. Box 68760. this

Livingston

1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec 21, <sup>Day</sup> 2004 **Physician** LOLITA LIVINGSTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LaPlata Civista Medical Center Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. NOV 13 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 1923 Months 81 075 18 5785 Director Usual Residence of Decedent 10b County 10c. City. Town or Location 10a State 27 is marked other than "natural", or itams 23a or 28a-f show traumatic avant, the McJical Examinat must be motified at P.G. FT. WASHINGTON MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 403 BOGOTA DRIVE 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after ☐ Yes 2√ No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify: BLACK þ If Yes, Give Year or Dates: 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. h and Mental Hygiene. 7 is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be L.C. DANCY IRENE JORDAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar trat once. IRMA L. MORGAN/NIECE 403 BOGOTA DR. FT. WASHINGTON, MD. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FERN CLIFF CEM. 12/29/04 HARTSDALE, N.Y. ' 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WATSON 3435 14th ST., N.W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of). ian/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ DIABETES-TYPE-TI Completed OBSTRUCTIVE CHRONIC 24a. Was an autopsy perform MASS LUNG 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? A Hospital or Attending Plant Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier MD D-26064 30 Name and address of person who completed cause of death (Item 23a) (Type Print) Vidyasagar Anmangandla, MD Rt 5 & Golden Beach Rd Charlotte Hall,

Approximate Interval Between Onset and Death HEART DISEASE 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 12-21-2004 2. Registrar's Signature **ORIGINAL** 

State

31. Date filed (Month, Day, Year)

DEC 2 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Day Month Voar **Physician** Phillip Gene Lumsden 12:15 AM DECEMBER 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** VAMARYLAND HEALTH CARE SUSTEM EKR DINT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1☐XM 2□F Yrs Director 554-58-8105 JAN 18. 1945 North Dakota Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Ceci1 Maryland Perryville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 21903 Items 23e 5288 Pulaski Highway, Room 109 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Viacht 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Ottned Forces? Vietnam

1 Types 2 No Vietnam

If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ō 1 ☐ Yes 2 🗓 No Specify Specify by 3 Widowed 4 Divorced White "naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ent: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Aircraft Maintenance United States Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Lumsden Rosie Yaroslaski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lovel I. Lumsden/Brother 199 East Biggs Highway, Biggs, California 95917 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State January 6, 1 ☐ Burial 2 X Cremation 3 ☐ Remoyal from State West Chester. ö permit. Page Department of Importent: If any injury or once. 2005 4 ☐ Donation , 5 ☐ Other (Specify) R.A. Ferris & Co. Inc. Pennsylvania 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Juneral Service Lin 23a. Part1. Enter the disease, or conshock, or heart failure. List only polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART Physician ONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit be executed Due to (or as a consequence of) use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Be Completed pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 21 No 1 Yes 2 No or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Certification: To After death. after death Director: ģ

21215-0036

Maryland

Baltimore,

Box 68760,

Records.

of Vital

Division

2

大グロセン

NAME

within 24 hours a

To the Funerel C

completely filled

Medical

State

30. Name and address of person who completed ca SUKH DEV S. AU 31. Date filed (Month, Day, Year) JAN 6 - 2

5 Pending investigation

6 ☐ Could not be

determined

2005

1 Natural 2 Accident

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier

se of death (Item 23a) (Type, Print)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

LAND HEALTH CAME SYSTEM PERRY POINT VAMARY 10. 32. Registrar's Signature

1 Yes 2 No

Registrar DHMH 17 Rev 1/2001 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe 1 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 108 MOSEPH ORTON 22 04 NATHANIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HEARTS CUMBERLAND If Under 1 Year If Under 24 Hrs. SACRED ALLEGHANY HOSPITAL 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**2**M 2□ F Months Hours Min. Director 216-56-1980 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Item 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Medical Examinar must be notified at SALISBURY 1 Yes 2 No Director ICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7520 2180 HVE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be illed within 72 hours after c Department of Health and Mental Hyglene. Importent: if Item 27 is marked other than "naturel", or Item any injury or other treumatic event, Ite Medical Exacilinat once. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PEARLY ERALDINE MORTON LOMAX 19a. Informant's Nam elationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DALSBURY MD 2 1801 20c. Location - City or Town, State 8099-BURNT BRANCH DR. HAROLD MORTON ~ BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) SALISBURY 28/04 21. Signature of Fundal Service Licensee 22. Name and Address of Facility SMITH SALISBURY MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESPIRATORY FAILURE Immediate Cause (Final Physician 1 Hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Effusion Examiner Prunce MALIGNANT WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit LUNG CARCINOMA The law requires that the death certificate be executed MONTH S Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION ATRIAL 1 ☐ Yes 2 ☐ No 3 Probably 4 ŪUnknown Completed EXCESSIVE ANTICOAGULATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HISTORY CONGESTIVE ASART FAILURE 2 🗌 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? fo the Hospitel or Attending Physicien: Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes 1 Inpatient 2 PER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12/22/04 Unhon D0042840 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ree A. Erickson 900 Columbia Mdi SatoN 31. Date filed (Month Pav. Year) . Registrar's Signatures State 2004 DEC alus. Registrar

			1- For Unpend Item 23a,27,28a f per me		_	_	
				rtificate of Death		NO 0 0 L	42391
	Physicia	an	Decedent's Name (First, Middle, Last)      TOSERIL DEFER MACERNO.	MA DDW	2. Date of Death December	r 31, 2004	3: Time & Death 1 14:15 PM
	/Medic Examin	al er	JOSEPH PETER MASTRO  4a Facility Name (If not institution, give street and number) 13903 Coastal Highway	4b. City, Town, or Location of Death Ocean City		4c. County of Death Worcester	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthpl	ace (State or Foreign try)
5	Director		228 54 2864 G2 Yrs. Usual Residence of Decedent		11-9-	-42	OHIO
	ryland ihow		10a. State 10b. County 10c. City, Town or L			10	Od. Inside City Limits
	he Ma 28a-f s	ecto	Md. Worcester Ocean	City 10f. Zip Code	100	. Citizen of What Coun	1 Yes 2 No
	3a or 3	Dir	10e. Street and Number 13708 Sand Dune Road	21842	109	U.S.A.	tiy!
	death	nera		Was Decedent of Hispanic Origin? (Sport Yes, specify Cuban, Mexican, Puerto	acify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Erain in finite tradities at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 Yes 2 No Specify:		Specify:	ite
5-0	"natur	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16	ib. Kind of Business/Inc	lustry
121	l within lene. r than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	Military		U.S. Go	vernment
pu	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " 7 raumatic event, tto Med	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Surname)	
yla	Ment Ment Parkec	일	Andrew Mastronardy	Mildre			0-4-1
Mar	id 2 sh Ith and 27 is m traum			ling Address <i>(Str</i> eet and Number or Rura 708 Sand Dune Ro			
Je,	of Health of Health litem 27 i		20a. Method of Disposition 20b. Place of Disposition	position (Name of permatory or other place)		c. Location - City or To	
Baltimore,	Page ment c ant: ff lury or		'4 □Donation 5 □Other (Specify) Salisbu	,	3-05 S	Salisbury.	, Md.
Balt	permil. Pages. Department of I Important: If ite any injury or of		The state of the s	22. Name and Address of Facility  J11rich Funeral	Home Be	erlin, Md.	21811
			23a. Part 1 Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Zolpidem Intoxica	tion			Onot and board
	Examiner		Due to (or as a consequence of):				
	D ==	iner	Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury that the conditions of the cause of the				
	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
760,	le be ex ysician e burial	calE	d				
89	leath certificate attending phy I for use as the	Medi	IF FEMALE:				
Вох	eath ce attend for use	Physiclan/Medi	23b. Was decedent pregnant in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ry Day Year
P.O.	t the de by the a	hysic	1 Yes 2 No 9 Unknown				
S, F	as tha gned se de	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to th	e cause of death? ably 4 Winknown
Sorc	v require been si should b	eted			24a. Was an	T	osy findings available
Rec	sician: The law certificate has t irector, page 2 s	Completed			autopsy performe	prior to cor death?	npletion of cause of
ita	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?		h (Check only one)	3110	
)t <	Physic this ce al direc	은	1 Yes 2 No Cospital 1 Inpatient 2 ER/Outpati			ce 6 Xother (Specify	At Scene
on 0	ding F h. After funera	tlon	27. Manner of Death  1 Natural 2 Accident  28a. Date of Injury (Month, Day Year)  Found  28b. Time Found  Found  28b. Time	Work?	28d. Describe how		100
Division of Vital Records,	or Attanding Physician: after death. Diractor: After this certifics in by the funeral director, I	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f Location (Street	ngested dru et and Number or Rura <sup>State)</sup> 13903 Co	Route Number
Ö	ital or ars afte ral Dir		Found on golf cour	rse grounds	cean Cit	y, Ma	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deadlers on the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	e and place, and due to	the cause(s)
	Mith To 1	2	29b. Signature and title of certifier	29c. License number O.C.M.E.		nuary 1, 20	
E.T	3+1		30. Name and address of person who completed cause of death (Item 23a) (Type AR (ITEM 23a) (Type AR (ITEM 23a) (Type ITEM 23a)	Penn Street, Balt	imore, Ma	ryland 212	01
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 0 5 2005	Sperle			

Mary Muller

			For State Registrar	State of M	arylan			nt of He e of D		nd Mer		giene Reg. No.	004	4239	2
	sicia		Decedent's Name (First, Middle, Las     MARY KI	emp MULLEI	2						Date of De Month	Day	Year 2004	3. Time of Deat	
	edic mine	er	4a. Facility Name (If not institution, give Genesis Health	street and number) Care - I	he I			Eas	ocation of D	Death		4c. Co	ounty of Dea	ath ot	
Fune Direc			5. Social Security Number 6. Security Number 217-07-1857  Usual Residence of Decedent	9X 7. Ag □ M 2 X F	e (In yrs. 88	Yrs.	If Under Months	Days	Hours	Min. M	Date of Bir ARCHI	th Year 19	16 9. Bi	irthplace (State or Fore Country) ARYLAND	aign 
Maryland		tor	10a. State 10b. County  MD TALBO	OT	10c. City	y, Town or La	cation ASTO	٧		-				10d. Inside City Lin	
ith with the 23a or 28		al Director	10e. Street and Number 610 DUTCHMANS L.	ANE			10f. Zip	2160	)1			10g. Citize	n of What C USA	•	
is 5, INICAL FIGURE A. I.C. I.C. I.C. I.C. I.C. I.C. I.C. I	- T- T- T- T- T- T- T- T- T- T- T- T- T-	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 1 If Yes, Give Year or Dates:			Was D <i>ec</i> e f Yes, spe 1 □ Yes		panic Origin Mexican, P Specify:	? (Specify Puerto Ric	y Yes or No an, etc.)		Black, Wh	nerican Indian, lite, etc. WHITE	
d within 72 h giene.		Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or	5+)	(Give	kind of wo	se retired)	on ring most of	f working			of Busines	·	
12 should be filed within hand Mental Hygiene.		To Be C	17. Father's Name (First, Middle, Last)  LEMUEL CARL KEMP  19a. Informant's Name/Relationship (7)	ype, Print)		19b. Mailir	ng Addres		MART	R AH1	REBECC	, Maiden St CA COX er, City or T		Zip Code)	
s 1 and 2 s of Health an item 27 is			JANET A. VIZZINI 20a. Method of Disposition	/DAUGHTER			DOWN	ING S'	r. EAS		MD 2	1601		or Town, State	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is	once.		1 Surial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	see	WO	FF	Name at	nd Address S, HE	of Facility LFENBI	EIN δ	NEWN	IAM FU	NERAL	MARYLAND HOME, P.A	٠.
Physici			23a. Part1. Enter the disease, or companies shock, or heart failure. List only immediate Cause (Final	blications that cause one cause on each I	d the deatl							MD 2	1601	Approximate Interval Between Onset and Death	
/Medic Examin	cal	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	neb.	VOVASI Lanca off.	alsı	msu	ficies	ney				george	
eath certifi	0.00	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3[	Ectopic p					230	d. Date of de Month	elivery Day Year	
w requires that the dispersion is been signed by the	alan an nin	ρ	Part II. Other significant conditions of	ontributing to death I	out not res	ulting in the u	nderlying (	cause given	in Part I.	_	23e. Did t	~		to the cause of death: Probably 4 □Unkno	
The law recate has been	page 2 suo	Completed									24a. Was auto perfo 1 Yes		24b. Were a prior to death?		able of
Physician: This certification	acior,	Be	25. Was case referred to medical examiner?	Hospital:				Other	26. Place of						
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has		tlon: To	1 Yes No  27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inji (Month, Da	ıry	ER/Outpatier 28b. Time o Injury		28c. Injury a Work?	4 Nursi	28d		dence 6 [ how injury o		ecify)	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After the Funeral Director: A	ed in by the	Certification;	3 Suicide 6 Could not be determined		jury - At ho tc. (Specif	ome, farm, str	eet, factor	y, office		28f.	Location ( City or To	Street and t wn, State)	Number or F	Rural Route Number,	
the Hospilin 24 hour	precenty min	edical		ysician: To the best niner: On the basis of and manner s	of examina		vestigation	n, in my opir	nion, death			date and pl	ace, and du	ue to the cause(s)	
with To 1	5	M	29b. Signature and title of certifier	MALLO	Syl	0		c. License	7593	99		29d. Date :	signed (Mor	nth, Day, Year)	
			30. Name and address of person who	My MD	508	B IDI	Print)	WD 1	PVENU	الح	EA	STCN,	MO	21601	
Reg	Sta gistra		31. Date filed (Month, Day, Year)	0	rar's Signa	te A	and a	-				•			

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / D  State of Maryland / D  Registrar		rtment of F				giene Reg. No.	004	42393		
			Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year  3. Time of Death									
	Physici /Medio		Audrey M. Mattingl		December 26, 2004 7:35A								
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o			th 4c. County of Death					
			13108 Monroe Avenue	, )	Fort Was					ince Ge			
	Funeral Director		5. Social Security Number $193-24-0843$	rs.	Months Days	Hours	Min.	8. Date of Bird (Month Da 2/3/32	n y, Year)	9. Birthi Cou	olace (State or Foreign ntry) Sylvania		
	ס		Usual Residence of Decedent					2/0/02		1 Cili	Syrvanita		
			10a. State 10b. County 10c. City, Town								10d. Inside City Limits		
	Be-1 s	cto	Maryland Prince George's Fort Wa	ish:	.,						1 ☐ Yes 2 🕅 No		
	with th	Dire	13108 Monroe Ave.		10f. Zip Code 20744				_	n of What Cou	ntry?		
	eath is 23.	erai	11. Marital Status 12. Was Decedent Ever in U.S.	13 V		ienanic Or	igin2 (Spe	cify Yes or No	USA	l. Race - Ameri	can Indian		
(0	r itan	Fun	Armed Forces?		Vas Decedent of H Yes, specify Cuba			Rican, etc.)		Black, White,	etc.		
03	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2 <b>X</b> No	Specify			S	pecify: Whi	te		
2-0	72 h	etec	15. Decedent's Education 16a. I (Specify only highest grade completed) (	Give	ent's Usual Occup kind of work done OO NOT use retired	ation during mos	st of worki	ng	16b. Kind	of Business/In	dustry		
121	within	Completed by Funeral Director	Elementary/Secondary (U-12)   College (1-4or 5+)		ewife	1)			Λ+-	Home			
9	filed Hygid other ant, I		17. Father's Name (First, Middle, Last)	, ab	ZWIIC	18. Moth	er's Name	(First, Middle,					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28e-1 show any injury or othar traumatic event, It a Modical Extended to the notified at once.	To Be	Harold Cromer Spade			Rho	da El	len Bis	shop				
lary					g Address (Street								
					Rolling	Oak 1							
Baltimore,	ges 1 It of H If ita		1 Burial 2VVCremation 3 Bemoval from State	, cren	sition (Name of natory or other place			ate		ation - City or To			
Iţi.	nt. Pa rtmer rtant: njury		'4 □Donation 5 □ Other (Specify) Kalas  21. Signature of peneral Service Ligensee		ematory		12/27			water,M			
Ba	permi Depar Impo any ir		A A A A A A A		eo. P. Kalas Funeral Home								
			23a. First. Enter the diseast, or complication of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one calls on each line.  Approximately a such as cardiac or respiratory arrest, interval in the calls.										
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Advanced Colorectal Carcinoma										
	/Medical		resulting in death)  a. Advanced Colorectal Calcinolia  Due to (or as a consequence of):										
	Examiner	<u>.</u>	Sequentially list conditions, b.										
		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
Ć,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of	f):		-				-			
8760,	sate be executed obysician and the burial-transit	dicai	d										
9	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	0	IF FEMALE:										
Вох		jan/	23b. Was decedent pregnant in the past 12 months? 1☐ Live birth 2 ☐ Fetal death			23	23d. Date of delivery  Month Day Year						
o.		Physician/M	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)   9   Unknown										
Δ.		by Ph	Part II. Other significant conditions contributing to death but not resulting in	derlying cause giv	en in Part	l.	23e. Did to	e. Did tobacco use contribute to the cause of death?					
Records,	w require been sig should b	ed b							′es 2□	No 3 ☐ Prob	pably 4 XUnknown		
ဝ၁ခ	law as b 2 sl	Completed			24a. Was an autopsy findings prior to completion of c								
	The cate has page	Com							performed? death?  1 Yes 2 No 1 Yes 2 No				
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		3 DOA Oth	00		(Check only o					
of	Phys this ral dir	Т.	1 Tes 2 VINO 1 Inpatient 2 EH/Outp		Home 5   Residence 6 □Other (Specify)  28d. Describe how injury occurred								
on	Attending I r death. actor: After by the funer	tion		28b. Time of									
Division	Attendi ar death. actor: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify)	n, stre	eet, factory, office		- 2	28f. Location (S City or Tow		Number or Rura	d Route Number,		
Ö	rs after or rel Dire		Suitally, etc. (Opecity)						on, olulo,				
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death /or inv	occurred at the tinestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurre	and due to the and at the time,	cause(s) ar date and pl	nd manner as s lace, and due to	tated. the cause(s)		
	To the within 2 To the complet	Med	29b. Signature and title of certifier		1 49c. Licens	e number			29d. Date :	signed (Month,	Day, Year)		
1 Halm & Jun 0101030768								12/27/04					
0	30. Na To and address of person who could proted cause of de this (Item 23a) (Type, Print)												
1			Patrick J. Byrne 1.D. 8505 Arling	tor	Blvd. S	uite	400	Fairfax	, VA. 2	22031			
	Sta Registr	45	DEC 2 8 2004  2. Registrar's Signature	204	W								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 20,2004 Physician 5:35 Ам GEORGE н. MILLER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Dec. 5, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XM 2□F Massachusetts 264-18-5304 85 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "neturel", or Items 23a or 28e-f show the Medical Expressional by collified at Rockville 1 ☐ Yes 2 No Md. Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20851 2101 Rockland Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: I flem 27 Is marked other than "neturel", or Ite important or other traumatic event, the Medical Exprision outs. 1 X Yes 2 No WWII Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify:White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Engir 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mechanical Drafting, Design Elementary/Secondary (0-12) College (1-4or 5+) Engineering 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marie A. Downey Lawrence L. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5838 River Oaks Court Frederick, Md.21704 Jackie Queen (Daughter) Dec. 21, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) Metropolitan Crem. Alexandria, Va. 2004 22. Name and Address of Facility Devol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ASPIRATION INELLHONIA /Medical Due to (or as a consequence of) Examiner ATRIAL Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) use as the burial-transit been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 2 Fetal death Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Tes 1 Yes Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Npatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending М 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 0-27660 104 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 11119 PIKE RU MD 208 Gos 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 22 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 19, 2004 **Physician** 7:53 Caroline Westbrook Malloy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery Holycross Hospital 8. Date of Birth (Month, Day, Year) Aug. 17,1921 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗙 F Director 071-12-8902 83 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23a or 28e-1 show any injury or other treumatic event, if a Nedicul Exam activities at ODGE. 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits Md. Kensington 1 ☐ Yes 2X No Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 United States 3402 Anderson Road Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 2 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be Ellen Van Vleck Robert Westbrook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12803 Bluet Lane Silver Spring, Md. 20906 Maureen White (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. ` 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Md. 2004 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral Home witer 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1957 Crisis **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of) Leukemia Examiner Myelogenous Chronic years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760 Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? õ Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2**X** No 1□ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. 28d. Describe how injury occurred Injury at Work? Certification: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ceter December 20, 2004 021910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter B. Shere mp 3921 Ferrara

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month, Day, Year)

DEC

2 2 2004

32. Registrar's Signature

wheaton, mo

			For Stata Registrar	State of M	arylan		artment			and M	_	giene Reg. No.	004	42396	
	Physici	010	Decedent's Name (First, Middle, Last)     2. Date of Death								ath Day	Year	3. Time of Death		
	/Medic			la Mae Mil							December 26, 2004   12:15 a <sup>M</sup>				
	Examir	ner *	4a. Facility Name (If not institution, gi						Location o			4c. C	County of De		
	F	Α.		goon Drive		last birthday)	If Under		Depo If Under 2		8. Date of Bir	th		ecil	
	d within 72 hours after death with the Maryland jiene. I than "neture!, or items 23e or 28e-f show than "neture! Franciscal Examiner must be notified at			1□M 2⊠F	84	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan.	iy, Year) 20 <b>,</b> 19	20	nthplace (State or Foreign Country) Maryland	
			Usual Residence of Decedent  10a. State 10b. County		100 City	/. Town or Lo	antina								
		ō		: 1	Too. Oily	7, 10 <del>4</del> 11 01 L0		D +	Dane					10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
		Director	Maryland Cecil Port Deposit  10e. Street and Number 10f. Zip Code							OSIL		10a. Citize	en of What C		
		Funeral Di							)4	and the state of t		U.S			
			11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl						gin? (Spe	cify Yes or No	- 14	4. Race - Am Black, Wh	erican Indian,		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🔯 If Yes, Give			1 ☐ Yes 2		Specify:	,	, , , , ,		Specify:	White	
15-00	hours turel'	To Be Completed b								16b. Kind of Business/Industry					
	nin 72 In "ne Medic		(Specify only highest grade completed) (Give kind of work done during most of work  Elementary/Secondary (0-12) College (1-4or 5+)						of workii	king			rial Hospital		
212	filed within Hygiene. Ither than "		Six Years  College (1-4or 5+)  Nursing Assistan						ant		Havre	Havre de Grace, Maryland			
Maryland 21215-0036	d tal		17. Father's Name (First, Middle, Las	•					18. Mothe	r's Name	(First, Middle				
	should be and Mental marked o		Frank A  19a. Informant's Name/Relationship			405 14-33		/01					Davis		
Mai	W 3		•	(Daughter	•)						<i>Route Numb</i> eposit,			21904	
	s 1 and 2 of Health a item 27 is other tran		20a. Method of Disposition	,	20b. Pf	lace of Dispo	sition (Nam	e of			ate			r Town, State	
mo			1 🖫 Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Spec			pewell				12/3	0/04	Port	Depos	it, Maryland	
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Ligarity	ALENN.	50	Le Le	Name and	Address	of Facility	n &	Son Fur d 219	neral	Home,		
	~		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause one cause on each I	d the death	. Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,	.00	Approximate Interval Between	
	by Medical be executed with a second of the		Immediate Cause (Final disease or condition	. Cener	more	Swim	AMI	pent						Onset and Death	
			resulting in death)	Due to (or as	a consequ	ence of):	1,		_						
		e.	Sequentially list conditions,  B. Due to (or as a consequence of):												
		Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
8760,		edical	Ca Minone onstruct pulmony							Myn	m promo				
9	entific ding pl	/Mec	IF FEMALE:	23c If yes outcome	of pregna	nev					<del>                                     </del>				
Вох	The law requires that the ate has been signed by the page 2 should be detached.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1								23	23d. Date of delivery  Month Day Year			
o.		hysi	1 ☐ Yes 2 🖾 No 9 ☐ Unknown 9 ☐ Unknown												
S, P		ру Р	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the un	nderlying ca	use giver	n in Part I.		23e. Did to	obacco use	contribute t	o the cause of death?	
ords			25. Was case referred to medical examiner?								1 Yes 2 No 3 Probably 4 Munknown				
Vital Records,		Completed									24a. Was an autopsy findings availab prior to completion of cause of			utopsy findings available completion of cause of	
al H											performed? death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No				
Zit.	8 8	o Be									ath Check onl one				
of		H :	1 Inpatient 2 EHOutpatient 3 DOA 4 Nursing Home								ne 5 ⊠ Residence 6 ⊡Other (Specify) 8d. Describe how injury occurred				
Division	Hospitel or Attendin 4 hours after death. Funerel Director: Aftely filled in by the fur	atlor	27. Manner of Death 1												
ĭ Vis		tifle	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Ö			Only U. Town, State)												
		ledical	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									s stated. e to the cause(s)			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Mon	th, Day, Year)	
,			P/(5W) 414	n MD				14t	14/2			14	21/03	0	
	6		30 Name and address of person who	completed cause of c	death (Item	23a) (Type, I	Print) (M	A	1	L	106	ml	n 21	18	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	rar's Signat			_ / _ V	*		[ ]	1.01	/V		
	Registr	ar	DEC 2 7 2004	Blown	Jr.	Sparle	1								

			T location	State of Ma		)enartmen				-		gibic.		
			For State Registrer	State of Ma	•	Certificate			ALICE IVI		2	nni.	100	20 7
			negistrer     Decedent's Name (First, Middle, L	.ast)		Cortinoati			1	2. Date of Dea	Reg. No.	OOF	3. Time of	Death
	Physici		Willia	m Robert Mo	ore Sr					Month Decemb	Day	Year 2004	2155	РМ
	/Medio Examin		4a. Fecility Name (If not institution, g		ore, br		Town, or	Location o	of Death	Decemb		unty of Death	12133	Г
			3 Stoney Chase	Drive		Ell	cton				C€	ecil		
	Funeral			Sex 7. Age	(In yrs. last birt	Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Year)	9. Birthp	place (State o	r Foreign
	Director		158-22-7727	73		Yrs.	-,,			DEC 5,	1931		Jersey	r
	and		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location							0d. Inside Ci	ty Limits
	f sho	ō	Maryland Ceci	1	E1kt								1 🗌 Yes	•
	158 - 288 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -	Director	Maryland Ceci  10e. Street and Number	±	LIKU	10f. Zip	Code				10g. Citizen	of What Cour	ntry?	
	3a o		3 Stoney Chase	Drive		21	.921				Unit	ed Sta	tos	
	deatl	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Deced		spanic Orig	gin? (Spe	city Yes or No-		Race - Americ	an Indian,	
ထ္ထ	or Ite	F	1 Never Married 2 Married		0	1 ☐ Yes		Specify:	, 1 401101	110a11, 9(0.)		Black, White,	etc.	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f show the Medical Examinat must be notified at	Completed by Funeral	3 Widowed 4 Divorced	Year or Dates:	1.00							Wh:	ite	
5	n 72 nat	lete	15. Decedent's (Specify only highest of	grade completed)		Decedent's Usua (Give kind of wor life. DO NOT us	al Occupa rk done d se retired	ition <i>luring most</i> }	of workir	ng	16b. Kind o	of Business/In	dustry	
12	withi iene. than	d Wo	Elementary/Secondary (0-12)	College (1-4or 5+		Welder	, , , , , , , , , , , , , , , , , , , ,	,			Dre	dging		
5	Hyge other ent,	Be C	17. Father's Name (First, Middle, La.	st)		WEIGEI		18. Mothe	r's Name	(First, Middle,		-3		
Maryland	uld be Menta rked tlc ev	To B	William Benjami	n Moore, Sr				Mary	y Pet	ti				
ary	sho and h is ma		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street a	nd Numbe	r or Rura	Route Numbe	r, City or To	wn, State, Zip	Code)	
Σ.	and and in 27	1	Blinda Sue Moor	e/Wife		Stoney (								
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or 28e-f show any figury or other treumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	☐Removal from State	20b. Place of cometer	Disposition (Nam y, crematory or o 'erris &	ne of ther place		Dece			on - City or To Cheste		
Ē	Pag tment tent: jury		* 4 ☐ Donation 5 ☐ Other (Spec	cify)	Co. Tr	iç.			30,	2004	Penns	sylvani	la'	
ga H	permit Depar Impor Impor any In		21. Signature of Funeral Service Lic	ensee		22. Name an Hicks	d Addres Home	s of Facility for .	y Fune:	rals, P	.A.			
_	au se a		23a. Part 1. Enter the disease, or co	marker that caused t	ha death Dor	103 W.	Sto	ckton	Stre	et El	kton.	Maryla	Approximate	
			shock, or heart failure. List or	y one cause on each line	). -	or enter the mod	e or dynig	j, such as	cardiac o	103pilatory all	iest,		Interval Bett Onset and [	ween
ľ	Fnysician /Medical		disease or condition resulting in death)	a. COP	D									
	Examiner			,	consequence	Anten		1000						
7		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	of):	3 "	1301	3-					
1	cuted nd ransii	Examiner	Cause (Disease or injury that initiated events	c										
760,	ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a	consequence	of):								
	cate b	dlcal	•	d										
9 x	Attending Physicien: The law requires that the death certifica rideath. actor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	by Physician/Med	IF FEMALE:	23c. If yes, outcome o	f pregnancy						024	Data of delive		
P.O. Box 68	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death	3 ☐ Ectopic pro						Date of delive Month	•	'ear
0	the d by the ached	nysi	1 Yes 2 No 9 Unknown	9□ Unknown			,,							
	s that ned b	y PI	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying ca	ause give	n in Part I.		23e. Did to	bacco use c	ontribute to th	e cause of d	eath?
ğ	quire an sig		Hygerter	0510~7						1 🗆 Y	es 2□No	2 Prob	ably 4 □U	nknown
Division of Vital Records,	law re as be 2 sho	plet	fremin							24a. Was a		b. Were auto	psy findings a	available
Ĕ	The late has page	Completed		,						perfor	med?	death?		1036 01
/ita	cien: ertific ector,	Be (	25. Was case referred to medical examiner?						of Death	(Check only or	ne)			
5	hysio this co	2	1 ☐ Yes 2 X No			tpatient 3 DO		4 🗀 1401		ne 5 Resid			1)	
Ž	ling F After unera	on:	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 285. 1	ime of 2 njury M	8c. Injury Work	at ? ′es 2 ⊡ N		8d. Describe h	ow injury oc	curred		
<u>s</u>	death ctor: y the	licat	2 Accident investigat 3 ☐ Suicide 6 ☐ Could not	be Ope Bloom of Injur	v - At home, fai			62 5 1		8f. Location (S	treet and Nu	ımber or Rura	l Route Numi	ber.
<u> </u>	after after Dire	Certification;	4 ☐ Homicide determine	building, etc.	(Specify)	, 511551, 14515. y	, 000			City or Tow				
	To the Hospitel or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 € Certifying	Physicien: To the best of	my knowledge	, death occurred	at the tim	e, date and	place, a	nd due to the c	ause(s) and	manner as st	ated.	
	he Ho in 24 he Fu pletel	edical	(Check only 2 Medical Exone)	aminer: On the basis of e and manner state	examination and	Vor investigation,	in my op	inion, deat	h occurre	d at the time, o	date and place	ce, and due to	the cause(s)	
	Vith To t	Σ	29b. Signature and title of certifier				. License				-	ned (Month, i	Dey, Year)	
			15/5 15	MD			00	060	064	+9 N 552	12	2-8 (	)4	
	5		30. Name and address of person wh			Type, Print)	223	TON				1		
	Sta	te	BALLINGT 31. Date filed Man Day, Kéar)	ON PROH	's Signature	Section 1	: LX	1 0 10	, 1	ND 2	117	1		
	Registr		- SENT TO ZUL	10 10000	10 19									
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			State of Maryland / Department   Certificate		lental Hygie	ZIIIIla	42398
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Tilda Munsey		December	26 2004 4c. County of Death	1815 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, To Union Hospital Elkt	own, or Location of Death		Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		lace (State or Foreign try)
	Director		233-60-0763 79 Yrs.	Days Hours Min.	JAN 29, 1	1925 West	Virginia
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Maryl -1 sho	ţō	Maryland Cecil Elkton				1 XYes 2 ☐ No
j	h the	Funeral Director	10e. Street and Number 10f. Zip Co	ode	10g.	Citizen of What Coun	try?
7 7	23e c	aiD	246 Hollingsworth Manor 219	921	1	United Sta	tes
3	er dea	nuel	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 2 No	nt of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒No If Yes, Give 1 ☐ Yes 2 ☒ 3 ☒Widowed 4 ☐ Divorced Year or Dates:	No 'Specify:		Specify: Whi	to
21215-0036	2 hou eture		15. Decedent's Education 16a, Decedent's Usual (	Occupation	16b	. Kind of Business/Inc	ustry
215	thin 7 e. e. "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	done during most of worki retired)		uto/Train	
7 5	led w tygier her th		6 Machinist 17. Father's Name (First, Middle, Last)	10. Adoth and a blom a		lanufacturi	g 
and	d be fi	o Be	Raleigh Roberts	Jane Bal	(First, Middle, Maid	ien sumame)	
	2 should be filed within 72 hours after death with the Maryland and Montal Hygiene. is marked other then "neturel", or Items 23e or 28e-1 show eumatic event, the Madical Examitrational be mailified at	ပ္		Street and Number or Rura		ty or Town, State, Zip	Code)
Baltimore, Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Montal Hygiene. If item 27 is marked other then "neturel; or Items 23e or 28e-f show or other treumatic event, the Modical Examiliar must be multified at		Tilda Munsey/Self 246 Holling	sworth Mano	r, Elkton	, Maryland	21921
or e	of He		20a. Method of Disposition  1  Surial 2  Cremation 3  Removal from State  1  Surial 2  Cremation 3  Removal from State	of Decem	nber 20c	. Location - City or To	wn, State
Ë	Pages Iment of I tent: If its jury or o		'4 □Donation 5 □ Other (Specify) Memorial Park	$\frac{1}{2}$ 31, 2	2004 E	lkton, Mar	1and
- Bai	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee Hicks H	Address of Facility Ome for Fune Stockton Str	rals, P.A		
8760, N	Physician /Medical Examiner  per partial-transit	lical Examiner	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	of dying, such as cardiac o	à.		Approximate Interval Between Onset and Death
P.O. Box 68	certifica ading ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delive Month	y Day Year
	The law requires that the death Ite has been signed by the atter bage 2 should be detached for u	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did tobacc	co use contribute to th	5.0
eco	law relas be	Completed	Anxrety		24a. Was an autopsy	prior to con	sy findings available
<u> </u>	10 L	Con	Holi cholesterol		performed		2□ No
Vita	Physicien: this certificaral director,	Be	25. Was calle referre medical examiner?	26. Place of Death			
Division of Vital Records,	nding Physith. : After this e funeral di	tion: To	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA  27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	Other: 4 Nursing Hor Injury at Work? 1 Yes 2 No	me 5 ∐ Residence 28d. Describe how in		)
Divis	tel or Atters safter des	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) The Destroy of the basis of examination and/or investigation, in and manner stated.	my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	Viti To CO	Σ	29b. Signature and title of certifier	icense number	290.	Date signed (Month, L	vay, rear)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	7120109	
_	5		223 W Main Street Elkhon,	m 020	den (	coksay	Bourm
	Sta Registr		JAN 1 0 2005  JAN 1 0 2005  JAN 1 0 2005				

			1 - For State Registrar			nd / Depa		of H	ealth a	and N	Mental Hy		000		1.00	^ ′
			1. Decedent's Name (First, Middle, L	ast)							2. Date of De	ath		127	3. Time of Deat	1
	Physic		Ruth Lorraine N	tiros							Month Decembe	Day er 22		Year 004	2:00 a	М
	/Medi Examii		4a. Facility Name (If not institution, ga	ive street and numb	oer)		4b. City, To	own, or	Location	of Death			County		2.00	
			Montgomery Gene	ral Hospi	tal		01ne	ey.				N	onto	rome	·v	
	Funeral		Social Security Number     6.		Age (In yrs	. last birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th			place (State or Fore	eign
	Director		347-20-8990	1 ☐ M 2 🔀 F		76 Yrs.	Moriais	Days	110013		April 2		928		linois	
	p s		Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or Lo	nation								04 1	
	sho	5				•									0d. Inside City Lin 1 ☐ Yes 2 ☑	
	the Marylar 28a-f show	ect	Maryland Monto	gomery	Re	ockvill										140
	with a or	급					10f, Zip C	ode				10g. Citi	izen of W	hat Cou	ntry?	
	eath	Funeral Director	14242 Briarwood	12. Was Decede	ent Ever in I	IS 13 '		353	enanie Ori	igin? (Sp	ecify Voc or No		USA 14 Page	Amari	ean Indian,	
	fter d	퍕	1 ☐ Never Married 2 ☐ Married	Armed Force	es?						ecify Yes or No Rican, etc.)			k, White,		
036	urs a	þ	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	No 🖸	Specify:				Specify:	Whi	te	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show he Modeat Expr. directment be notified at	ted	15. Decedent's l	ducation		16a. Dece	dent's Usual	Оссира	tion			16b. Ki	nd of Bu	siness/In	dustry	
21	thin 7	pie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work DO NOT use	retired)	uring mos	it of work	ing					
	filed wi Hygien other th	Completed	12			Hom	emaker	-				0	wn H	lome		
nd	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, ILE M.	Be	17. Father's Name (First, Middle, Las	(t)					18. Mothe	er's Nam	e (First, Middle,	Maiden	Sumame	∍)		
<u>yla</u>	should be find Mental harmarked of	2	Clyde Stotler						G1	adys	Ploens	e				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 Ia marked other than "natural", or Itams 23a or 28a-f should then traumatic event, the Modical Execution trust be notified at		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (	Street a.	nd Numbe	er or Run	al Route Numbe	er, City o	r Town, S	State, Zip	Code)	
	s 1 and 2 of Health item 27 other tr		Stephen Ntiros	Son	Look		2 Bria		od T	erra	ce, Roc					
Ore	Pages 1 nent of Hi ant: If iter		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from Sta	ľ	Place of Dispo cemetery, crer	natory or oth	of er place	)   D	ecen	nber 27,	20c. Lo	cation - (	City or To	wn, State	
Ë	Pa tmen tant: jury		`4 ☐ Donation 5 ☐ Other (Spec	ify)		klawn Me			į	20	04	Rock	vill	e. M	aryland	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	ensee		F	rancis	Address	s of Facilit	lins	Funera	1 Ho	me I	nc.		
	0 0 ≥ e ot		Thendule			5	<u>00 Uni</u>	ver	sity	Blv	d, W, S	ilve	r Sp	ring	, MD 209	
П			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau y one cause on eac	sed the dea h line.	th. Do not ent	er the mode	of dying	, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	a Lun	Canc	cer									Onset and Death  5 Years	
	/Medical Examiner		resulting in death)	Due to (or	as a conse	quence of):										
		Ļ	Sequentially list conditions,	b												
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clause of Injury	Du e Do (or	as a conse	quence or):										
	xecut and Il-trar	xan	that initiated events resulting in death) Last	c. Due to (or	as a consec	guence of):										
09	ate be executed hysician and the burial-transit	cal E				1										
68760,	icate phys s the	900		d												
×	eath certific attending p for use as	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pregn	ancy							2d Data	مر طمائدہ		
Вох	atter 1 for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnan			Ectopic preg						3d. Date Mont		Day Year	
P.O.	at the de by the a tached	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow												
	g g g		Part II. Dther significant conditions	contributing to deat	h but not re:	sulting in the ur	nderlying cau	se givei	n in Part I.		23e. Did to	obacco u	se contrit	bute to th	e cause of death?	
Records,	n signe	d by	Pneumonia, Pulmo	nary Embo	olism						101	/es 2[	]No 3	3 🗀 Prob	ably 4 🛣 Unknow	WΠ
8	w requ	Completed									24a. Was	an	24b. W	ere auto	osy findings availal	ble
Re	The lav	ш					-				autop	rmed?	pr de	ior to cor eath?	npletion of cause of	of
Vital		C	25. Was case referred to medical						OC Bloom	-4 D4	1 Yes		1 [	□Yes	2 □ No	
5	Physician: this certific ral director,	O B	examiner? 1 ☐ Yes 2 【本No	Hospital: XXInn	ationt 2	ER/Outpatien	+ 3□ DOA				n <i>Check onlo</i> me 5 ☐ Resid		C Other	(Canail		
of		E	27. Manner of Death	28a. Date of I (Month,		28b. Time of		. Injury	at		28d. Describe h				"	
ion	nding I ath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investigation		Day Year)	Injury	М	Work'	? es 2.⊟!	No						
Division	Attendi ir death. ector: A by the fu	Hice	3 Suicide 6 Could not I	28e. Place of	Injury - At h	ome, farm, stre fy)	eet, factory, c	office		1	28f. Location (S	Street and	/ Number	r or Rura	Route Number,	-
Ö	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	4 🗌 HORIKIGƏ	bullaing,	etc. (Speci	ry)					City or Tow	n, State)				
	To the Hospital of within 24 hours all To the Funeral D completely filled in		29a. Certifier 1  Certifying P	hysician: To the be	st of my kno	owledge, death	occurred at	the time	e, date an	d place,	and due to the	cause(s)	and man	ner as st	ated.	
	n 24 he Fu	Medical	(Check only 2 Medical Exa	miner: On the basis and manner	s of examina stated.	ation and/or inv	estigation, in	my opi	nion, deat	th occurr	ed at the time, o	date and	place, ar	nd due to	the cause(s)	
	withi To t	Σ	29b. Signature and title of certifier				29c. L	icense	number			29d. Date	signed	(Month, I	Day, Year)	
•			Dr. Liture He	inz- Ho.	MUG.	ric	D	005	3542		D	ecer	BER	- 22,	2004	
3)	^-		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type, I	Print)								1	
~ C	0		Libuse Heinz-M	omcilovic	, M.D	. 1150	Ol Geo	rgia	Ave	nue,	#515,	Whea	ton,	MD	20902	
	Sta		31. Date filed (Month, Day, Year) UEC 23	2004 32.85	istrar's Sign	ature										
	Registr	ar	DEC 20	LUU4	CHE.	N. A.	220011									

ysicia	an	1 - For State Registrar  1. Decedent's Name (First, Middle, La		•	tificate of		2. Date of D	Reg. No	2004 Year	3. Time of Dea
Medic amin	al	John Vernon Nic			4b. City, Town,	or Location of	Decemb f Death	4c.	County of Dea	3:40
eral ctor		218 09 1859	Sex 1 M M 2 □ F 7. Age (In yrs. Ia	a <i>st birthday)</i> Yrs.	Elkton If Under 1 Yea Months Days			lirth Day, Year)	0	rthplace (State or Fo ountry) yland
tified at	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland Cecil	10c. City,	, Town or Lo	cation					10d. Inside City Li 1 ☐ Yes 2
ant be no	al Director	10e. Street and Number 23 Woods Way			10f. Zip Code 21921				izen of What C	
edical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 M Yes 2 No 196 If Yes, Give Year or Dates: 196	43-	Was Decedent of f Yes, specify Cu		in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Am Black, Whi Specify: Wh:	
Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give life. L	tent's Usual Occi kind of work don DO NOT use retir	upation e during most red)	of working	16b. Ki	ind of Business	/Industry
event, the	ø	12 17. Father's Name (First, Middle, Las	()	_Elect	rician		's Name (First, Middi		ctrica Sumame)	1
traumatic ev	T	19a. Informant's Name/Relationship				et and Numbe	e H Hall r or Rural Route Num	-		Zip Code)
any injury or other traumatic ev		Frances Nickle/W:  20a. Method of Disposition  1 XBurial 2 Cremation 3 ( 4 Donation 5 Other (Space)  21. Signature of Funeral Spance Lice	□Removal from State Nor	ace of Dispo- metery cren th Eas Cemet	sition (Name of natory or other pl t Method ery	dist I	Date Dec. 28, 2004 Crouch Fu	20c. Lo	cation - City or	Town, State
cian		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aMYOCALD	Do not ente	er the mode of dy	ying, such as o	Street, Nor eardiac or respiratory		st,Mar	Approximate Interval Between Onset and Dea
iner	-	Sequentially list conditions,	b. HYPEATEA	اجرها						YEARS
the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CEREBLOV	ASCULA	M DISE,	AsE				YEARS
or use as	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of pregnar  1 Live birth 2 Fetal  4 Pregnant at time of de	death 3	Ectopic pregnan	су			23d. Date of de Month	livery Day Year
should be detached	by P	Part II. Other significant conditions	contributing to death but not resul	lting in the ur	nderlying cause g	given in Part I.				o the cause of death
9 2	Completed						24a. Wa aut per 1 □ Yes	opsy formed?	24b. Were a prior to death?	utopsy findings avai completion of causi
irector, pag	o Be (	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1   Inpatient 2   E	ER/Outpatien	t 3 DOA		of Death (Check only sing Home 5	_	6 □Other (Spe	
ne funeral di	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inj W	ury at lork? Yes 2 \( \)	28d. Describe			City)
etely filled in by the	Certification;	3 Suicide 6 Could not determined	building, etc. (Specify)	)			City or To	own, State	)	ural Route Number,
completely filled in	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinati and manner stated.	ledge, death on and/or inv	occurred at the vestigation, in my	time, date and opinion, deat	I place, and due to the h occurred at the time	e cause(s) e, date and	and manner a I place, and du	s stated. e to the cause(s)
	×	29b. Signature and title of certifier				nse number ン <b>お</b> ててい			e signed (Mon	th. Day. Year)
COM		, \			_	- 1 1 - 5			-1.5-11	-1 -1

			1 - State Amend Item 18 Registrar		aryland / Dep	artment of Ho 28a-f per prificate of L	ealth and Mer ne G839 1- leath	ntal Hygier 19-05 ta Reg. N	ne Las Las O O La	421.01
	Physic		DAVID  Bare (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent's Name (First, Middle, Lateral DAVID)  1. Decedent N		GBURN			Date of Death Month C ecember 2	29, 2004	3. Time of Death  15:00 M
	/Medi Examii		4a. Facility Name (If not institution, give 2410 Spencerville	e street and number)		4b. City, Town, or Spencery	Location of Death	4	c. County of Death	1
3	Funeral		Social Security Number     6. S	Sex 7. Age	e (In yrs. last birthday 24 Yrs.	1	If Linder 24 Hrs o	Date of Birth (Month, Day, Yea	Montgomery 9. Birthp	lace (State or Foreign
3	Director		216-96-1337 Usual Residence of Decedent				Se	ept./,L	.980 Mai	rýland
	Marylar f show	ō	10a. State 10b. County  MD Prince	Cádraca	10c. City, Town or L	aurel			1	0d. Inside City Limits  1X☐ Yes 2 ☐ No
	ith the Marylan or 28e-f show	Director	10e. Street and Number	Géorges		10f. Zip Code	20708	10g. C	Citizen of What Cour	itry?
	oma 23a	Funeral	13506 Gamb	12. Was Decedent E Armed Forces?		Was Decedent of His	spanic Origin? (Specify n, Mexican, Puerto Rica	Yes or No-	U.S.A.  14. Race - Americ Black, White,	
980	ours afte	by	Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XN If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 🙀 No		, σ.σ.,		Lack
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28e-f show any injury or other treumatic avent. The Medical Exerction count for notified at once.	Completed	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5 L Vr	+) (Giv.	edent's Usual Occupa e kind of work done di DO NOT use retired) Dieticia	uring most of working		Kind of Business/Inc Laurel I Hospital	Regional
nd 2	e filed at Hygi sother vent, I	Be Co	17. Father's Name (First, Middle, Last				18. Mother's Name (Fi			<u> </u>
ylaı	nould by Ments	To	Clayton Co		1700			nne Ogb		
Ma	nd 2 shallth and 27 le n		Joanne Ogburr				nd Number or Rural Ro ad Ave.,			
imore,	Pages 1 a nent of Hea ent: If item ary or othe		20a. Method of Disposition  1 Surial 2 Cremation 3 C  4 Donation 5 Other (Special	Removal from State	20b. Place of D sp cemetery, cre	osition (Name of matory or other place n Cem	Date 1/5/05		Location - City or To	
Balti	permit. Departn Importe any injt		21. Signature Freeral Service Licer	See Plus	11/11/		s of Facility SNOV sh. St.,			Children Control Control Control Control
68760,	filicate be executed was g physician and physician and street transit as the burial-transit.	edicai Examiner	23a. Part1. Enter the disease or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Intoxica Due to (or as a	mia Compl	icating Me	, such as cardiac or re: Ethylenadio	xymetham	nphetamine	Approximate Interval Between Onset and Death
P.O. Box 68	t the death cert by the attending ached for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ( time of death 5 (	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ry Day Year
	w requires that been signed should be del	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the t	inderlying cause giver	n in Part I.		use contribute to th	
Division of Vital Records,	iician: The law re certificate has bec rector, page 2 sho	Completed						24a. Was an autopsy performed? 1 Yes 2 □ N	prior to con death?	psy findings available apletion of cause of
Vit	yaician: iis certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	Cthor	26. Place of Death (Ch 4 □ Nursing Home		Other (Specify	SCENE
sion of	ttending Phydeath. ctor: After thi y the funeral o	ation; T	27. Manner of Death  1 Natural 5 Pending investigation	Found, Day	Year) 28b. Time o	of 28c. Injury		Describe how inju		
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 & Could not be determined	28e. Place of Inju- building, etc. Scene	ry - At home, farm, st (Specify)	reet, factory, office	28f.   <b>Rd.</b>	Location (Street a City or Town, Star Spence	nd Number of Rural te) 2410 Sp rville. M	Route Number 111e
	ne Hospl n 24 houn ne Funer pletely fill	Medical	29a. Certifier (Check only one)	ysician: To the best o niner: On the basis of and manner stat	examination and/or in	h occurred at the time evestigation, in my opio	e, date and place, and on nion, death occurred at	due to the cause(s t the time, date ar	s) and manner as stand place, and due to	ited. the cause(s)
1	To ti Withi To ti comp	Ž	29b. Signature and title of certifier	-		29c. License			ate signed (Month, E	**
,		0	30. Name and address of person who		eath (Item 23a) (Type, 111 I	Print)	C.M.E. t, Baltimon		ember 30,	
	Sta	te	31. Date filed (Month, Day, Year)	JB10 HD 32. Agistra			, Dartinoi	e, rary.	rand ZIZU	<u> </u>
	Registr		JAN 05 2	1005 Street	r's Signature					

			For State	State of Man				Mental Hygie	ene	
			Registrar/MEND#8perFH12/  1. Decedent's Name (First, Middle, Last,		b Ce	rtificate of L	Jeath	Reg 2. Date of Death	. No.	The Allenda
п	Physici	ian						Month	Day U Uyear	3. figher (Feath)
	/Media		John H.  4a. Facility Name (If not institution, give	Ourand		4. 0. 7		Dec. 19,	2004	
	Examir	ner		,		4b. City, Town, or	Location of Deat	h	4c. County of Deat	h
			Suburban Hospita  5. Social Security Number 6. Secu		n yrs. last birthday)	Be 1	thesda If Under 24 Hrs	To Date of Birth	Montgome	
	Funeral Director			M 2□F	71 Yrs.	Months Days	Hours Min.	(Month, Day, Y	1933 9. Birt	hplace (State or Foreign untry)
			Usual Residence of Decedent		71			Dec. 16,	<del>2004</del> Was	hington,DC
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Man Fish	ţŏ	D.C. None		Washingt	on				1 X Yes 2 ☐ No
	1 the	rec	10e. Street and Number		washinge	10f. Zip Code		10a	. Citizen of What Co	untry?
	3a o	Funeral Director	6117 Western Ave.	N.W.		200	15		USA	,
	death ms 2	Jere		12. Was Decedent Eve		Was Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Race - Ame	ncan Indian.
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 is marked other then "natural", or items 23s or 28e-1 show other traumatic event, the Medical Evaninet must be notified at	by Fur	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	1953-   '	f Yes, specify Cubar 1 □ Yes 2🛣 No	n, Mexican, Puèri Specify:	o Rican, etc.)	Black, White	
ð	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occupa	ıtion	161	D, Kind of Business/	
715	nin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired)	uring most of wor	rking		i idddiy
21	filed within Hygiene. Ither than "	E	Elementary/Secondary (0-12)	4	Direc	tor of Pr	ocuremer	it	NASA	
b	e file othe vant,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, Mai	den Sumame)	
<u>a</u>	Mental	To B	Charles H. Ourand				Eileen	Dougherty		
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic ●vant, I'e.M	_	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a		ral Route Number, C	ity or Town, State, Z	ip Code)
	and 2 salth a n 27 is		Rosemary M. Ourand	/Wife	6117	Western A	Ave., N.	W. Wash.,	D.C. 2001	5
re	es 1 and 2 of Health I itam 27 I		20a. Method of Disposition		Date 200	. Location - City or				
Ĕ	mit. Pages bartment of loorent: If its cinjury or of		1 XBurial 2 □ Cremation 3 □ R  1 4 □ Donation 5 □ Other (Specify)	emoval from State	Gate of	sition <i>(Name of</i> natory or other place Heaven Ce	m. Dec.	2004' Si	lver Spri	ng. MD
Baltimore,	7 5 4 5		21. Signature of Final Service License	e can	22	. Name and Address	s of Facility De	Vol Funer	1 Home	
m	Depar Impor any ir		hun A xe	ll	230		2222 W	isconsin D.C	Ave N.W	•
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the	death. Do not ente	er the mode of dying	, such as cardiac	or respiratory arrest,	. 20007	Approximate
	Physician		Immediate Cause (Final		1600-6	CARNA	than Color	A A . C	2 4	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):	CHEISID	MICH	M DISCA		YEAR
	Examiner				, , , , , , , , , , , , , , , , , , , ,					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a eu	nsequence or).					
	outed ad ansit	Examin	Cause (Disease or injury that initiated events							
ó	an ar rial-t		resulting in death) Last	Due to (or as a co	nsequence of):					
68760,	ficate be executed g physician and st the burial-transit	edicai	d							
-		Jed	IE EE MIE		-					
Вох	The law requires that the death certifi te has been signed by the attending bage 2 should be detached for use as	Physician/M	200. Was decedent program	3c. If yes, outcome of pa 1 Live birth 2 □	regnancy	Ectopic pregnancy			23d. Date of deliv	very
	dea death	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time 9☐ Unknown	of death 5	Other (specify)			Month	Day Year
O. O.	at the de by the stached	hy	9 🗆 Unknown							
Ś	res tha igned b	by	Part II. Other significant conditions con		_	derlying cause giver	n in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ord	w requir been si should I	ed	IMMOBILITY DU	20 71	79515			1 ☐ Yes	2 No 3 Pro	bably 4 Onknown
ည္က	aw re	ompieted	ANDYIC BRAIN	I WARE Y				24a. Was an	24b. Were aut	opsy findings available
æ	: The lav	E						autopsy performed	? death?	empletion of cause of
of Vital Record		Se C	25. Was case referred to medical				26. Place of Dea	th (Check only one)	NO I TES	21 <b>3</b> NO
<b>f</b> <	ys dii	0 8	examiner?	ospital:	2 R/Outpatient	Other		ome 5 Residence	6 ∏Other (Speci	fv)
	ig Ph	ü	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury a		28d. Describe how in		
Ö	Attanding I ir death. ector: After by the funer	atic	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mentil, Day 18	injury		es 2 🗆 No			
Division	ial or Attandi s after death. al Director: A ed in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S		et, factory, office		28f. Location (Street City or Town, St	and Number or Rur	al Route Number,
	tal or	Cer		panang, oto. (o	poony			Only of Fown, St	ale)	
	To the Hospital or within 24 hours after within 24 hours after To the Funeral Directompletely filled in b	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my	/ knowledge, death mination and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the cause red at the time, date a	e(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2 To the comple	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.  29b. Signaffine and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)						Dav. Year)		
	⊢≯Fö	D 31027						and and		
	20		20 Name and officer of	melated course	/ltem 00=\ 7=		ULF	12	. 11-20	
			30. Name and address of person who con		OLD OLD	GEWIGETU	WN RA	S. BETT	HOSDA W	NS 20814
	Sta Registra	7.	31. Date filed (Month, Day, Year) <b>NFC.</b> 2.2 200	32. Degistrar's S	Signature &	Sparks				

Amend item//II. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		<ol> <li>Decedent's Name (First, Middle</li> </ol>	, Last)					2.5	Date of Dea	th.		Come Come
Phys		Mildrod	В.	(	Neal			1	Month	Dav	Year	3. Time of Death
/Me Exan	dical niner	4- 5- 30- 11- 45- 11- 1			Near		4b. City. To	own, or Locatio	ecembe		2004	12:23 p.
LAUIT	illici	Garrett Memor		pital					ii oi boaiii		,	
Funera	al		6. Sex		rs. last birthday)	If Under 1 Y	ear If Under	1and	ate of Birth		rett	o /Ctata as Fassi
Directo		235-44-4374 Usual Residence of Decedent	1□ M 2🂢 F	75	Yrs.	Months Da	ays Hours	Min. (/	b 5,	Year)		ce (State or Foreign) Virginia
nylan how		10a. State 10b. County		10c.	City, Town or Lo	ocation					10d	. Inside City Limit
Be-f s	Director	WV Prest	ton	T	Cerra A	lta						1X Yes 2□N
or 2	Dire	10e. Street and Number			·	10f. Zip Coo	de		1	0g. Citizen of	f What Country	?
ath w	ral	500 Shaffer Ave	e Apt 50	4		2676	54			U.S	S.A.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Modical Examinating the notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 🛣 Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or De	rces? 2 <b>XX</b> No re	lf	Was Decedent f Yes, specify 0 1 ☐ Yes 2 🛣			res or No- n, etc.)		ace - American ack, White, etc	
2 hou	- p	15. Decedent's		1105.	16a Deced	dent's Usual Oc	ounation				Whit	
within 7% jiene.	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1	-4or 5+)	(Give ) life. D	kind of work do	ne during mos tired)	st of working			Business/Indus Home	try
i Hyg other	BeC		ast)		HOM	emaker	18. Mothe	er's Name <i>(Fir</i> s	t Middle N			
fenta fenta iked iic ev	0	Golden Kirk						dred Ma			,	
shound IV	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailine	g Address (Str						ido)
and 2 valth a 27 is		Thomas Sigley				1, Box						
of He item		20a. Method of Disposition		20b.	. Place of Dispos cemetery, crem	sition (Name of	nlaco)	Da			- City or Town,	State
Pag nent: If		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		rate	mpground			1/3/	2005	Tunno 1	ton, W	7
mit.	à	21. Signature of Funeral Service Li-	censee	1		. Name and Ad		t/J/	2005	Tumer	LOII, W	V 
		111111111111111111111111111111111111111		. 1								
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Physiciar /Medica Examine	/Medical Examiner	Immediate Cause (Final disease or condition	a. Acute	Pue to Cast Due to Cast Due to Cast Due to Cast	291 ath. Do not ente  1 Failur (or as a consequ	5 South re uence of): tial B1 uence of): nfarcti	Price dying, such as eeding	Stroot	King	wood,	Ap Into On	proximate erval Between set and Death
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			1- State of Maryland /		rtment of H			jiene leg. No.2 0 0	14 42404
	Physici	an	Decedent's Name (First, Middle, Last)     CLARENCE MC CLELLAN O'BII	FR	-		2. Date of Dea Month	th	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	
2	Lxaniiii	ÇΙ	Southern Maryland Hospital		Clin			Prince	e George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last t		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	1 9	9. Birthplace (State or Foreign
L.	Director		5/8-48-0811 6/	Yrs.			FEB. 7,	1937 V	VIRGINIA
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Many -f sh	tor	MARYLAND CHARLES WA	ALDOI	RF				1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wh	at Country?
	72 hours after death with the Maryland natural, or Items 23a or 28a-f show Acal Examiner must be notified at	Funeral Director	3407 WILLIAMSBURG DRIVE		206	04		UNITE	ED STATES
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	s afte	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never 1955 - If Yes, Give Year or Dates: 1958	1	☐ Yes 2☐XNo	Specify:		Specify:	
9	"natural", or items			a. Deced	ent's Usual Occupa	ation		16b. Kind of Busin	WHITE ness/Industry
215	within 72 ene. than "ns he Wedi	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	kind of work done of OO NOT use retired	during most of work ()	ring		,
212	e filed within all Hygiene. other than vent, the we	Completed		HEAVI	EY EQUIPM	ENT OPER	ATOR	UNION	
nd	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam			
yla	2 should be and Mental is marked o	٩	CLARENCE EDWARD O'BIER				MURIEL W		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28a-f show or other traumatic event, the Medical Examiner must be multified at		5111		g Address (Street a HUNT SQU				
	s 1 and 2 of Health a item 27 is other trai		20a Method of Disposition 20b. Place	of Dispos	sition (Name of	DROP		20c. Location - Ci	
nor	ages ant of it: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemet		natory or other place EM • GARDE	-/	IDEK		MARYLAND
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee M00053		Name and Address	1	2004	WALDORF,	MARTHAND
m	Department Department		Mark St. Brokening	P.	ntt Funer 0. Box 1	rai Home 156, Wald	orf. MD	20604	
	*		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente					Approximate Interval Between
M	Physician		Immediate Cause (Final disease or condition	IVE	HEAR	T FAIL	YRE		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence	e of):					
b	Examiner	_	Sequentially list conditions, b. COLONAS		ARTER	Y DISE	HE		
	ed	Examiner	Fauly, leading of immediate cause. Enter Underlying Cause, Disease or injury	a 317.					
	xecut and al-trar	xan	that initiated events c. Due to (or as a consequence	e of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit		d						
89	ifficate g phys as the	Physician/Medical							
Box	leath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal deal	th 3	Ectopic pregnancy			23d. Date of	,
	ne deat the attr	sicla	1 Yes 2 No 4 Pregnant at time of death		Other (specify)			Month	n Day Year
P.0	ac o	Phys	9 Unknown				oo. Dida		
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting  DIABETES MELLIT			en in Part I.	238. Did to		ute to the cause of death?  Probably 4 Dunknown
O.C.	neen s	eted	CHRONIC OBSTRUCTI			MOUNDY			
3ec	e la has	Completed	CHRONIC OBSTRUCT	IVE	DISEAS	MONARY	24a. Was a autops perforr	y pric	re autopsy findings available or to completion of cause of ath?
a	ici <b>an</b> : The l certificate ha rector, page		OF Manager started to medical		DISEAS		1 ☐ Yes 2	2, <b>23</b> No 1□	Yes 2 100
Division of Vital Records,		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 Impatient 2 ☐ ER/C	Jutnation	Othe	26. Place of Deat er: 4 ☐ Nursing Ho			(Specify)
of	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b.	. Time of	28c. Injury Work			w injury occurred	
ion	al or Attending Ph s after death. al Director, After th ed in by the funeral	Certification:	1 万Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		Yes 2 □ No			
i≺is	r Atte	tific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f. Location (St City or Town		or Rural Route Number,
	urs affi ral Di								
	To the Hospital or Atten within 24 hours after deat To the Funeral Director; completely filled in by the	edical	29a. Certifier (Check only one)   Weertifying Physicien: To the best of my knowledge of the control of the basis of examination and manner stated and manner stated						
	o the ithin 2 o the omple	Mec	one) and manner stated.  29b. Signature and title of certifier		29c. License	number	2:	9d. Date signed (/	Month, Day, Year)
	F ₹ F ŏ		) Legen		Di	2828	2 .	40-	BER 20,2004
(	1		30. Name and address of person who completed cause of death (Item 23a	ı) (Type, I	Print)				4
J	B259		Dr. Nelson V. Benjers, 9131 Pisca	taway	y Road, #	600, Cli	nton, MD	20735	
	Sta		31. Date filed (Month, Day, Year) 32. pegistrar's Signatur	4	rede				
	Registr	ar	DEO 11 ~ 200	-					

		•	a FOI	partment of Health and Meartificate of Death	ental Hygie	2001
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  THEODORE PROCTOR		2. Date of Death Month	Day Year 3.05 bm
	Examin Funeral		4a. Facility Name (If not institution, give street and number)  SOUTHERN MARYIAND HOSPITAL  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Lin 70 N  If Under 1 Year If Under 24 Hrs.	8. Date of Birth	4c. County of Death  PINCE LEERGE'S.  ar)  9. Birthplace (State or Foreign Country)
	Director		219 48 9423 XXM 2□F 56 Yrs.  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L		(Month, Day, Ye JUNE 26,	1948 WASHINGTON, DC
the Maryla	28e-f shor	Director	MARYLAND PRINCE GEORGES FORT WASI		10g.	Too. Inside City Elimis  ★★ Yes 2 □ No  Citizen of What Country?
r death with	ems 23a oi		2705 TUCKER ROAD  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	20744  Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	ify Yes or No-	UNITED STATES  14. Race - American Indian, Black, White, etc.
hours after	tural', or its	þ	XXNever Married 2 ☐ Married 1 ☐ Yes XXNo If Yes, Give Year or Dates:	1 ☐ Yes XX No Specify: edent's Usual Occupation		Specify: BLACK
od within 72	f Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23s or 28e-f show other treumetic svent, its Medical Examilitational be notilized at	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of working DO NOT use retired)  MAIL CLERK	7	PRIVATE
y laring hould be file	d Mental Hy narked oth netic svent	Be	17. Father's Name (First, Middle, Last)  WILLIAM EARL PROCTOR  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	18. Mother's Name (  ELIZABETH  ling Address (Street and Number or Rural)	I GRACIE	PROCTOR
s 1 and 2 s	f Health and Item 27 Is r other treur		ELIZABETH G. PROCTOR / MOTHER 2705  20a. Method of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Place Of Disposition 20b. Pl	TUCKER ROAD FOR	T WASHIN	GTON, MD 20744  Location - City or Town, State
permit. Pages	Department of Health a Importent: If Item 27 Is any injury or other tre once.		ABBurial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  RESSUREC'	TION CEMETERY 12/30		CLINTON, MARYLAND
9	nysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	308 SULTLAND KOAD	SULTLAN	D, MD 20746  Approximate Interval Between Onset and Death
1	Medical kaminer		resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.	Kidney failu	LE AHO	)
executed	hysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):	V HEN	10 DIALY	/Si S.
entificate be	ding physici se as the bu	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			
the death of	signed by the attending p d be detached for use as	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
equires that	been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the PERIPHERAL VASCULAR D	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
o the Hospitel or Attending Physicien: The law requires that the death certificate be executed	certificate has bu rector, page 2 sh	Completed			24a. Was an autopsy performed 1 Yes 2	
Physicien	this certil al directo	To Be	25. Was case referred to medical examiner?  1		e 5 Residence	6 □Other (Specify)
Attending I	r death. actor: After by the funer	Certification;	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	Work? M 1 ☐ Yes 2 ☐ No		and Number or Rural Route Number,
dospitel or	within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		4 ☐ Homicide building, etc. (Specify)  29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination and/or in the basis of examination and/	ith occurred at the time, date and place, an	City or Town, St	e(s) and manner as stated.
To the I	within 2.  To the I complet	Medical	29b. Signature and title of certifier  Mh	29c. License number 1 > 0 0 6 1 6 \$ 2		Date signed (Month, Day, Year)
	5)	B	30. Name and address of person who primpleted cause of death (Item 23a) (Type ATUL KAT-/AL, Suite 750 N			2n, CLIMON, MD
	Sta Regista		DEC 2 8 2004  2. Registrar's Signature	de la companya della companya della		,

DHMH 17 Rev 1/2001

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  LINDA MARIE  PREUSSE  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	2. Date of Death Month	Day Year	3. Time of Death
The Hooking Washall Walle		901000	104.20 H M
The state of the s		4c. County of Dea	
Director  213-50-5500  1 M 2 F 49 Yrs. Months Days Hours Min		Year) 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	rthplace (State or Foreign Jountry) New York
10a. State 10b. County 10c. City, Town or Location  Maryland Montgomery Silver Spring  10b. County 10c. City, Town or Location  Maryland Montgomery 10f. Zip Code			10d. Inside City Limits 1 ☐ Yes 2 No
106. Street and Number 2808 Clear Shot Drive, #4 20906	10	g. Citizen of What C USA	country?
The state of this panic Origin?  The state of this panic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	ite, etc.
	orking 1	6b. Kind of Business  Medica	,
The property of the property o	ame (First, Middle, M		
William N. Preusse  Marie  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F	e C. Siebe		7-0-4-1
William N. Preusse/Father  20a. Method of Disposition  20b. Place of Disposition (Name of			
The property of the property o	ember 21	Oc. Location - City of	r Town, State
201. Method of Disposition (Name of Disposition (	s Funeral	Home Inc.	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardio shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  ACUTE RES PRATORY DISTRESS SYNDROW.	. ,	st.	Approximate Interval Between Onset and Death
Examiner  Due to (or as a consequence of):  ACUTE KIDNEY FAILURE			1 MONTH
Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury)  POST TRANSPLANT LYMPHO PROLIFERATIVE  B. Due to (or as a consequence of):  POST TRANSPLANT LYMPHO PROLIFERATIVE			
that initiated events c.	DISEASE		1 MONTH
	IS TRANSPL	ANTS	5 YEARS
Spond was a large of the past of the past 12 months?  1   Spond of the past 12 months?   1   Spond of the past 12 months   1   Spond of the past 12 months   1   Spond of the past 12 months   1   Spond of the past 12 months   1   Spond of the past 12 months   1   Spond of the past 12 months   1   Spond of the past 12 months   1		23d. Date of de Month	olivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.  ACUTE REJECTION OF KIDNEY TRANSPLANT  PSEUDOMONAS CELLULITIES AND OSTED MYSILITIS			o the cause of death?
ACUTE REJECTION OF KIDNEY TRANSPANT  PSEUDOMONAS CELLULITIS AND OSTEO MYELITIS  25. Was case referred to medical examiner?  26. Place of December 19 per 19	24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of s 2 🕅 No
25. Was case referred to medical examiner?  1   Yes   2   Your    1   Yes   2   Your	eath (Check only one) Home 5 Residen		
	28d. Describe how		suly)
27. Manner of Death 1 Sk Natural 2	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
building, etc. (Specify)    Specific Continued	ce, and due to the cau curred at the time, date	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
Chatte II a	290	d. Date signed (Mont	
MD KES OOU		12/20 104	/
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MATHEW PIPELING, MD 600 NORTH WOLFE STREFT BALT IMPRE	e Mara A	212	07

10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show ust be notified at SE Director MARYLAND CHARLES NANJEMOY 10e. Street and Number 10f. Zip Code Po 4115 FRIENDSHIP LANDING RD. 20662 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) CAREGIVER 11 Pages 1 and 2 should be filed vitment of Health and Mental Hygie tent: If item 27 is marked other tigury or other treumatic event, III. 17. Father's Name (First, Middle, Last) Be WILLIAM EDWARD POSEY ZELDA MAY 19a. Informant's Name/Relationship (Type, Print) SHARONETTE POSEY-DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HOPE CEMETERY MT. 1-4-05\_ 21. Signature of Funeral Service Licenses Name and Address of Facility M00479 Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Ca C as a consequence of Box 68760. Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No o. 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an page 2 s autopsy performed? 1 ☐ Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes ÆNo 1 **G**inpatient Certification: To 2 ER/Outpatient 3 DOA funerai 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day Year) After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by 4 T Homicide 29a Certifier 29c. License number 29b. Signature and title of certifier aun MY D-46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** JANET ELAINE POSEY 2004 DEC.30. 5:06P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LAPLATA

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. CIVISTA MEDICAL CENTER CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2XF Yrs. 49 217-68-6757 SEPT. 23, 1955 NANJEMOY, MD Usual Residence of Decedent 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry PRIVATE HOMES 18. Mother's Name (First, Middle, Maiden Surname) GAINOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4098 BLUEBIRD DR., WALDORF, MD 20603 20c. Location - City or Town, State NANJEMOY, MD RAYMOND FUNERAL SERVICE, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac of espiratory arrest, and a specific control of the product of the Approximate Interval Between Poset and Death cus ears 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 20 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) ALIKHANI, MD P.O. BOX 1890 LAPLATA, MD 20646 MTRZA 31. Date filed Anh. 1ay Year 105 32. noyo State Sparke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

**Funeral** 

Director

		1 - For State Registrar	State of Maryland	/ Department of I Certificate of		ental Hygie Reg.		42408
	ysician	1. Decedent's Name (First, Middle, Last) SHIRLEY	POI	NDEXTER	+	2. Date of Death Month	Day G Year	3. Time of Death
Fur	Medical caminer neral	4a. Facility Name (If not institution, give stress of the second of the	Preet and number)  A BULTYMOVE  7. Age (In yrs. Ja: 53	2 Baltim		1. Date of Birth (Month, Day, Ye 5 - 28 - 19	nar)   Co	1 1 1 1 1
Wand yland		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		20 17	JI WIID	10d. Inside City Limits
Re-1 st	notified at	MD 10e. Street and Number	ВА	LTIMORE		10-	Citizen (Marie Co	1 Yes 2 No
23a or	al Dir	3600 REISTERST	OWN ROAD,		215	10g.	U . S . A	•
SWY LLY POW.  -0036  hours after death with the Maryland turel; or liems 23s or 28e-1 show	Examiner m	11. Marital Status 12 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 _Yes _Z ANO If Yes, Give Year or Dates:	. 13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
V ' LO 2 2	walkal seted	15. Decedent's Educa (Specify only highest grade of	ation completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working	16b	. Kind of Business/	
d 2121 filed within Hygiene.	r, the Mudical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	NURSING AS	SISTANT		PRIVA	ГЕ
V = 0 = 0	even Be	17. Father's Name (First, Middle, Last)  WARREN	REED		18. Mother's Name		den Sumame) LAWS	SON
<b>2 a</b> 5 a 1 € 5 a 1	treumatic	19a. Informant's Name/Relationship (Type		19b. Mailing Address (Street			ty or Town, State, 2	Zip Code)
ore,	r other	DAVID POINDEXTER.  20a. Method of Disposition  1	20b. Pla	7904 DRUM ce of Disposition (Name of netery, crematory or other pla VERDALE PK C	ce)	ate 20c	Location - City or	Town, State
Baltim Permit. Pag Department Important:	any injury o	21. Signature of Funeral Service Siconsee		22. Name and Addres	ess of Facility TAY	LOR'S F	UNERAL	HOME
Records, P.O. Box 68760, The law requires that the death certificate be executed by the attending physician and labels of the attending physician and labels.	lical	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a conseque	ult fespivat noe of): Nethallin noe of):	ng, such as cardiac or	trespiratory arrest, tress S	gndane veus)	Approximate Interval Between Cases and Death Cases and Death South
Cords, P.O. Box 6	etached for use as Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. ff yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic pregnancy	у		23d. Date of deli Month	ivery Day Year
dS, P ires that signed b	t be detail	Part II. Other significant conditions contri	ibuting to death but not resulti	ing in the underlying cause giv	ven in Part I.			the cause of death?
Division of Vital Records, to Attending Physicien: The law requires that redeath.  Director: After this certificate has been signe	page 2 should	Cardianyopa	thy (Isch	em2)		24a. Was an autopsy performed 1 Yes 2	24b. Were au prior to death?	topsy findings available completion of cause of
Vita rsicien: s certific	director,	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No	spital: 1 🛣 Inpatient 2 🗆 EF	R/Outpatient 3 DOA	26. Place of Death	Check on one	6 DOthor (Spec	264
Division of Vital Rec To the Hospitel or Attending Physicien: The law within 24 hours after death.	e funeral c	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		8b. Time of 28c. Injury Wor		8d. Describe how in		119)
Divis of or Atte after de	ed in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28	8f. Location (Street City or Town, St		ral Route Number,
ne Hospite n 24 hours	pletely fille edical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my knowled r: On the basis of examination and manner stated.	edge, death occurred at the tir n and/or investigation, in my o	me, date and place, ar opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
Totl	Com	29b. Signature and title of contilion	Tananh	29c. Licens	se number	29d. [	Date signed (Month	Day, Year)
D. (4		30. Name and address of person who com	pleted cause of death (Item 2				WINDLE	(1,00)
UP C	State	31. Date filed (Month, Qa), Year)	3 Registrar's Signatur	a sut	More			
Re	gistrar	DEC 2 7 2004	Dere &	Mark				

			1 - For State Registrar	State of Maryland	d / Department of <i>Certificate o</i>			ene g. No 2004	42609
	Physici	an	Decedent's Name (First, Middle, Last				2. Date of Death Month		3. Time of Death
	/Medi		Vannie Lee	Price			Dec. 15		11:15 a <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give		4b. City, Town	, or Location of Death		4c. County of Deat	
			3217 Prince Ra		Forest			Prince	
	Funeral		5. Social Security Number 6. S 2 4 9 - 5 0 - 9 8 1 4		4 Yrs. Months Day	s Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birtl	npface (State or Foreign untry)
	Director		Usual Residence of Decedent				5-25-19	30 Sout	h Carolin
	/land		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	Many -1 sh	to	MD Prince	George	Forestv	ille			1 XYes 2 No
	7.28e	Funeral Director	10e. Street and Number		10f. Zip Code	)	10	g. Citizen of What Co	untry?
	h witi	0	3217 Prince Ra	nier Place	20747	,		USA	
	deat deat	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		f Hispanic Origin? (Speuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
9	after or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🔯 No If Yes, Give	1 ☐ Yes 2基 N		ritoari, etc./	Black, White	lack
93	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show dreal Examitter over the motified at	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:	10103 2631	о арвену.		Specify:	
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121	within ene. then	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use reti	ewife		Private	
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Maryland	d fall	To Be	Robert Kenn			Adelin			
2	2 should the and Ment is marked burnatic e	ř	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Address (Stre	et and Number or Bura	d Route Number	City or Town State 7	in Code)
S	od 2 s Ith an 27 Is		Adeline Tatum/		B217 Prince			•	
	Heal Heal tem		20a. Method of Disposition		lace of Disposition (Name of semetery, crematory or other p			Oc. Location - City or	
lo I	ages ant of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specif	Indinovaliioni State	<sub>h. Nat</sub> 1 Се	$m \cdot 12-20$	0-04 S	uitland,	MD
Baltimore,	permit. Pag Department Importent: I Bny injury c		21. Signatur of Juneral Service Ligar	,		dress of Facility Tay I	low to E		
Ba	permi Depa Impo any is		1211			th Capito			
			23a. Part1. Enter the disease, or com	dications that caused the death	-				Approximate
	Dhartte		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	CANCER				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ					2 42ARS
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		je	Sequentially list conditions, if any, leading to immediate cause. It all IT dailying Cause (Disease or injury	Due to (or as a consequ	uence of):				
	cuted	Examiner	Cause (Disease or injury that initiated events	c.					
ó	an ar	EX	resulting in death) Last	Due to (or as a consequ	uence of);				
8760,	certificate be executed ding physician and ise as the burial-transit	licai		d					
9		Med	IF FEMALE:						
Вох		an/I	23b. Was decedent pregnant	23c. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal		ncy		23d. Date of deli-	very Day Year
	e dea he at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5 ☐ Other (specify)			Month	Day 19a1
P.0	law requires that the death as been signed by the atter 2 should be detached for u	Physician/Med			Mine to the conduct to a conduct	en en in Donal	22a Did taha		
S,	signed		Part II. Other significant conditions of					cco use contribute to	
orc	w requir been si should	ted	CHRONIC			2053 2	1 185	2 140 3 170	Dabiy 4 Donkhowii
Records,	e law has b je 2 st	Completed by	CONGESTIV	L HEART	FALLURE		24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
H	ate pag	Co					performe 1 ☐ Yes 2 £	ed? death? □No 1 □ Yes	2 <b>2</b> No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Maria Santa		26. Place of Death			
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ñ	ding F h. After funera	lon:	27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. In N		28d. Describe how	infury occurred	
Sic	Attending r death. sctor: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not b			☐Yes 2☐No	204 Lanation /Ctm	at a and Mumban an O	
Division	or All	Certification:	4 Homicide determined	building, etc. (Specify	me, farm, street, factory, offic ')	:8	City or Town,	et and Number or Rui State)	al Houle Number,
_	Hospitel 4 hours 2 Funerel   tety filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wladge, death occurred at the	time data and place a	and due to the cau	sea(s) and manner as	etatad
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Examone)	niner: On the basis of examinat and manner stated.	ion and/or investigation, in my	y opinion, death occurre	ed at the time, date	e and place, and due	to the cause(s)
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	111	29c. Lice	nse number	290	I. Date signed (Month	
			to the state of	olldess The	menino 7	028079		DECEMBER	-21,2004
.0	-(3)		30. Name and address of person with	completed cause of death (Item	23a) (Type, Print)	2010			
1	9			SHOWN 117	too BELTSVILLE	- DRIVE, B	ELTSULIE	MANECE	in
	⊸, Sta	ite	31. Date filed (Month, Day, Year) DFC 2 7 200	3. Registrar's Signat	ture book				
	Regist	ar	DEC 3 3 SOO	Tobbe A	Charles .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U U L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 18, 10:15 PM DEC. KALINDI RADEBAUGH 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Min. | MarCH | 13,1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF NORTH DAKOTA 74 Director 502-26-4277 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TYes 2 □ No MONTGOMERY LAYTONSVILLE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23521 POCAHONTAS DR. 20882 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LENARD **GREER ESTHER** LAE MASON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23521 POCAHONTAS DR., LAYTONSVILLE, MD. 20882 **JEFFREY** BREEN/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 12-22-2004 RIVERDALE, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A
MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 207 21. Signature of Funeral Service Licensee nambersan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PROSTHETIC AORTIC VALVE FAILURE /Medical Due to (or as a consequence of) Examiner THROMBUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed CARDIOGENIC SHOCK burial-tran the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physiclan/Medical CONGESTIVE HEART FAILURE the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by a Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 XNo funeral director, 25. Was case referred to medical 26. Place of Death\_(Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After or Attending 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the within 24 hours efter death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m Dec 18, 2004 16073 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 SHADY GROVE RD. #201, ROCKVILLE, MD.20850 KATHLEEN V. McSHANE, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 22 2004 DEC Registrar

				Maryland / Depa		of H	ealth a	-	•	nde.	1.21.11
			Decedent's Name (First, Middle, Last)		imouto	0, 2	Journ	2. Date of De		O - 7	3. Time of Death
	Physici		R. Raber Robins, Jr.					Month	er 21,	Year	11:30 a M
	/Medic Examir		4a. Facility Name (If not institution, give street and number	ar)	4b. City, T	own, or	Location of			ty of Death	11.30
			Manor Care-Chevy Chase		Chev	у С	hase		Mo	ntgom	erv
	Funeral			Age (In yrs. last birthday)	If Under 1		If Under 2	4 Hrs. 8. Date of Bir Min. (Month, Da	th		place (State or Foreign ntry)
	Director		199-03-2749 IND M 2 F	87 Yrs.	World	Days	Hours		3. 1917		nsylvania
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation						10d. Inside City Limits
	faryli sho ed a	5									1 Yes 2 XNo
	28e-	Director	Maryland Montgomery  10e. Street and Number	Silver S	opring 10f. Zip (	ode.			10g. Citizen o	f M/h at Carr	
	with Sa or		14400 Homecrest Road, #2	30	101.2.0	209	0.0		10g. Onizeri 0		•
	ms 2;	Funeral	11. Marital Status 12. Was Decede		Was Decede			in? (Specify Yes or No Puerto Rican, etc.)	- 14. R	USA ace - Americ	
9	or ite	Ē	1 Never Married 2 Married 1 ☐ Yes 2	No				Puerto Rican, etc.)		ack, White,	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show hs Madical Examinar must be notified at	Dy.	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Date	s:	1 ☐ Yes 2	∐ No	Specify:		Spec	ify: Wh	ite
5-0	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual kind of work DO NDT use	Occupa done d	tion uring most	of working	16b. Kind of	Business/In	dustry
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and	ould be f Mental H warked of	Be						's Name (First, Middle		Ime)	
2	should Men marke	2	Robert Raber Robins  19a. Informant's Name/Relationship (Type, Print)	19h Mailir	an Address /	Street a		ce R. Dolar or Rural Route Numb		n Ctate Zin	Code
Maryland	01 00 00		Janet M. Robins/Daughter								
ē,	Health tem 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name	of		Chevy Ch	20c. Location		
9	Pages nent of I ent: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta `4 ☐ Donation 5 ☐ Other (Specify)	te Burtonsville				ecember 27 2004	Punton	arri 17.	o Mo1
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensee	- Prince							e, Maryland
ñ	Dep Imp	(i) )	> O. Ken Skiles	50	rancıs 00 Uni	vers	COIL1 Sity E	ins Funeral	L Home ilver S	Inc. pring	. MD 20901
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ă	death a atte	icla	in the past 12 months?		Ectopic pred Other (spec						Day Year
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Ä	The late has page	E O						perfo	rmed?	death?	2 No
Vital	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place o	of Death Check on			
of V	S S	2	1 ☐ Yes 2 ☐ NO Hospital: 1 ☐ Inpa	tient 2 ER/Outpatien		-11-5-5	INUIS	sing Home 5 Resid	dence 6 🗆 O	her (Specify	1)
C		ü.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, L	jury 28b. Time of Day Year) Injury	280	. Injury Work	at ?	28d. Describe I	now injury occu	rred	
sio	Attending r death. ector: After y the fune	cati	2 Accident Investigation		М		es 2 □ No	_			
Division	o in the	Certification;	determined 286. Place of	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory,	office		28f. Location (S City or Tox		ber or Rurai	l Route Number,
ч	Hospital	ပိ	29a. Certifier 1 Certifying Physician: To the be	at of my knowledge, death		About Alexander	a data and				ata d
		edical	(Check only 2 Medical Examiner: On the basis one)	of examination and/or inv	estigation, in	n my opi	inion, death	occurred at the time,	date and place	, and due to	the cause(s)
	To the within 2	Me	29b. Signature and title of certifier		29c. I	License	number		29d. Date sign	ed (Month, l	Day, Year)
	->-0		1 Tunge	1 mb	1	0	05	7/24	121	22/	04
13	7		30. Name and address of person who completed cause o	death (Item 23a) (Type,	Print)			/		- /	
3)			Truong Boa MD 132	219 Execu	tive T	Park	Terr.	German	town !	ND F	20374
	Sta		31. Date filed (Month, Day, Year) 32. Tigis	strar's Signature							
ls s	Registr	ar	DEC 2 3 2004	we It for	render						

		•	For Stata Registrar	State of Ma	arylan	•	artmen rtificat					Rag. No.	0001	12112
	Dhusiai		1. Decedent's Name (First, Middle, Last,	)						2	2. Date of Dea	ath Day	Year	3. Time of beath
	Physici: /Medic		Earl Alvin Ros	enthal							DECEMBI	ER 2	5 2004	10:05 p <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give						Location o				County of Deat	
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	Funeral Director		5. Social Security Number 6. Se 1392-10-6407	x JM 2□F	84	last birthday) Yrs.	Months		Hours	Min.	B. Date of Birt (Month, Da April	Year)	1020 Wi	thplace (State or Foreign buntry) SCONSIN
		Ì	Usual Residence of Decedent		04						Aprii	10,	1920 WI	300113 111
yland	How He		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
e Ma	8-8	ctor	Maryland Charle	es		Walc	lorf							1 ☐ Yes 🔏 ☐ No
ë H	or 28	Olre	10e. Street and Number				10f. Zip	Code					zen of What Co	ountry?
ath w	238	- a	5104 Tarpon Court			- 1				206			SA	
er de	item Der 7	nu	11. Marital Status	12. Was Decedent I Armed Forces? 1 X Yes 2 □ N		S. 13.	Was Deced If Yes, spe-	dent of H cify Cuba	ispanic Orig in, Mexican	gin? (Speci n, Puerto Ri	ify Yes or No- ican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>	
)36 Irs aft	i, or	by F	1 ☐ Never Married 2 ☐ Married 3 【☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		-61	1 🗆 Yes	2 <b>X</b> No	Specify:				Specify: Wh	ite
21215-0036 sod within 72 hours after death with the Maryland	atura	Completed by Funeral Director	15. Decedent's Edu	cation	130,	16a. Dece	dent's Usu	al Occup	ation			16b. Ki	nd of Business/	/Industry
1215 within 7	Mad n	ple	(Specify only highest grad	College (1-4or 5	j+)	life.	DO NOT u	se retired	during most d)	t or working	7			
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			19a. Informant's Name/Relationship (T)										r Town, State, 2	Zip Code)
<b>e, –</b>	Department of Health Important: If item 27 any injury or other tra		Jessica Schroder-I  20a. Method of Disposition	aughter	20b. P	lace of Dispo	osition (Na	me of		_Wald	orf, M		603 cation - City or	Town State
Baltimore,	nt of I :: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ F		C	emetery, cre	matory`or o	other plac					/ ICC	
Iti	ortani injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligens			tt Cre			ss of Facilit		-2004	WdI	dorf, M	עו
Ba	Impo any once		Jack A. Cerilso	₩ M012	.40	- H	luntt	Fune	eral H	Home	out M	20	604-015	c
1	nysician and Medical xaminer por ness as the prival-transit	al Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Λ	a consequence a consequence	uence of):		+ 1	Aypul Hypul	ai -				Interval Between Onset and Death
387 icate	physic the	dlc	•	d										
. Bc	signed by the attending I be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	death 3	⊒Ectopic pi ⊒ Other (sp						23d. Date of del Month	ivery Day Year
<b>₽</b> ₫	ned b e deta	by PI	Part II. Other significant conditions co	ntributing to death b	ut not res	ulting in the u	inderlying o	ause giv	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
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The Tag	ate has page 2	EO									perfo	med?	death?	
Vital	is certificate director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death (	Check only o	ne)		
of Vita Physician:	this ce al dire	2	1 ☐ Yes 2 🗹 No	Hospital: 1 UInpatie		ER/Outpatie			4 LI NU				5 □Other (Spec	cify)
		Certification:	27. Mann of Death 1 ▶Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry y Year)	28b. Time of Injury		28c. Injun Worl			ld. Describe h	low injur	y occurred	
Division or Attending	death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	20 - Diago of lai	41 h		M		Yes 2□		of Location /	Stroot on	d Number or D	ural Route Number,
) V i	Direction by	it.	4 Homicide determined	28e. Place of Injude	c. (Specif	y)	reet, ractor	y, onice		20	City or Tow	m, State	)	arar noute rumber,
Cospitel	within 24 hours after death  To the Funerel Director: completely filled in by the f		29a. Certifier 1 Certifying Phy	sician: To the best	of my kno	wledne deal	th occurred	at the tin	ne, date an	d place an	nd due to the	cause/s\	and manner as	stated.
Hos	24 hi e Fur.	edical		iner: On the basis of and manner sta	f examina									
To the	vithin Fo the	Me	29b. Signature and title of certifier						e number			29d. Dat	e signed (Monti	h, Day, Year)
•	> - 0		M. M. HAIL	plan	MI	)		Do	5060	473		12	126/28	Ø14
			30. Name and address of person who co	ompleted cause of d	leath (Item	n 23a) (Type,	Print)				1			
Mi	1001		DR MEHRDAD AKHLA			S HOSP	ITAL	LEON	NARDTO	OWN MI	206	550		
	* Sta		31. Date filed (Month Day Year) 7 2	004 32. Fegistr	ar's Signa	turg A	park	1						

EARL A ROSENTHAL

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** CHRISTINE ROSE 27, RISNER 1:35 PM /Medical December 2004 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner McCready Memorial Hospital Crisfield Somerset If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2X F Months 226-38-8167 August 22, 1907 Missouri Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1DTYes 2 □ No Maryland Harford Churchville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 210 Hopewell Road 21028 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 🗓 No Specify: ğ Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Schnauppauf Genevieve Stindel 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4684 Jacksonville Road - Crisfield, Maryland 21817 Dorothy N. Pember (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sam Houston National Cemetery 1/4/05 an Antonio, Texas 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Mary Beth Bradshaw-Pruitt Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco us ontribute to the cause of death? 1 Yes 2 Tho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 000 1 ☐ Yes 1 🗆 Yes 200

**Physician** /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed

certificate

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s efter deeth.
I Director: After the in by the funere

within 24 hours e

To the P

filled in by

Box 68760,

Division of Vital Records, P.O.

permit. Peges 1 end 2 should be filed withir Depertment of Heelth end Mentel Hygiene. Important: if item 27 is marked other than eny Injury or other traumetic event, the Me

**Funeral** 

Director

r than "natural", or items 23a or 28a-f shor the Madical Examiner must be notified at

filed within 72 hours efter death with the Marylend

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Completed by

25. Wes case referred to medical exeminer?

200 1 Yes/ 27. Manner of Deeth

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 DFA/Outpatient 3 DOA 28b. Time of Injury

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

Maturel 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

29b. Signat

30 Neme e

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Fedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end marginer staged. 29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medicai Certification: To Be

deeth (Item 23a) ( 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

			For	State of Maryla	nd / Depa	artment of H	lealth and N	lental Hydi	iene	
			1 - State Registrar	,		rtificate of l		, ,	10 S.No.2	4 621.11.
	Dhyaisi	-	1. Decedent's Name (First, Middle, Last)	)	-			2. Date of Death Month	Day Yea	3. Time of Death
4	Physici /Media		HELEN	С.	STO	OCKTON		DEC.	21 200	
	Examir	ner	4a. Facility Name (If not institution, give				Location of Death		4c. County of De	
		1	ATLANTIC GENERAL  5. Social Security Number 6. Secu		. last birthday)	BER	LIN If Under 24 Hrs.	8. Date of Birth	WORCE	
	Funeral Director			M 201 8		Months Days	Hours Min.	(Month, Day, FEB. 18,	Year) 9. E	Sinthplace (State or Foreign Country) CAROLINA
3	2		Usual Residence of Decedent					FED. 10,	1/21	
5	show anyian	2	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
ā.	28a-f	Director	MARYLAND WORCESTE  10e. Street and Number	ER	OCEAN I					
with	l be		75 BRAMBLEWOOD D	ND T 17 E		10f. Zip Code		10	og. Citizen of What	Country?
death	ms 2:	Funerai		12. Was Decedent Ever in L	J.S. 13.	21811 Was Decedent of Hilf Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Ar	nerican Indian,
<b>6</b>	or Ite		1 ☐ Never Married 2 📉 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 🗓 No		Rican, etc.)	Black, WI	
21215-0036 d within 72 hours after death with the Maryland	De lieu within 72 hours after death with the marylat had Hygiene. The Hygiene do other than "natural", or liems 23a or 28a-f show avent. Its Modical Exteriulter maal be notified at avent.	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	WHITE
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	other ont.	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name			O V EIGHTEIN E
10 P	snould be and Mental I s marked o umatic sve	To B	CLYDE	McCALL			DELPH	IA	OWEN	
Maryland	f Health and Men them 27 is marke other traumatic		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address (Street a	and Number or Run	al Route Number,	City or Town, State	, Zip Code)
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altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	emoval from State	Place of Dispo cemetery, crer	sition (Name of natory or other place	Θ)	Date 2	Oc. Location - City of	or Town, State
tim	, 돈 뿐 중 .		*4 ☐ Donation 5 ☐ Other (Specify)	CR		OF DELMA		4/04 D	ELMAR, DE	CLAWARE
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death u	e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of a		Ectopic pregnancy Other (specify)			Month	Day Year
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Ords, P	500	þ	Part II. Other significant conditions con	tributing to death but not res	sulting in the ur	nderlying cause give	n in Part I.			to the cause of death?
		Completed			·			1 Yes	2 € No 3 □ F	Probably 4 Unknown
The law	has t	mple						24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
			00.14					1 ☐ Yes 24	No 1□Ye	s 2 No
OT VITAL	물용	Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1- Inpatient 2	TER/Outration	Othe	26. Place of Death			
	90 6	0		PLIMPANER 2L	I Ervoulpatien	t 3 DOA		ne 5 🗀 Hesiden 28d. Describe how	ce 6 □Other (Sp	ecity)
	- <u>0</u>	n: To	27. Manner J. eath	28a. Date of Injury	28b. Time of	28c. Injury	at	Luc. Describe non	v injury occurred	
ndin n	- <u>0</u>	$\vdash$			28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? ′es 2 □ No	204. 90301150 1101	vinjury occurred	
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			1 = For State Registrar	State of Maryla			nt of H te of L		nd Mental	Hygier	200	ls 421	15
			1. Decedent's Name (First, Middle, Las	et)					2. Date of		Day Ye	3. Time of D	Death
	Physicia /Medic		John Ignatius	Spriggs, Sr.					Decen				P M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit	, Town, or	Location of	f Death		4c. County of D		
			Ft. Washington						nington		Pri	nce Georg	
	Funeral		5. Social Security Number 6. S	XX M 2 DE	s. last birthday, Yrs.		er 1 Year Days	If Under 2 Hours	Min. (Monti	of Birth n, Day, Yea		Birthplace (State or Country)	Foreign
	Director		579-14-7758 Usual Residence of Decedent	86	113.				Aug.	11,	1918	Virginia	
	land ow		10a. State 10b. County	10c. (	City, Town or L	ocation						10d. Inside City	y Limits
	Mary F sh	ğ	Maryland Prince	George's		₽.	. Ua	- lo + +				1X Yes 2	2 🗌 No
	7.28a	rec	10e. Street and Number	George 5			ip Code	shingt	-011	10g.	Citizen of What	Country?	
	death with the Maryland ms 23a or 28a-f show r must be notthed at	O E	9603 Travers	Way				2074	44		linit	ed States	
	deat	Funeral Directo	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dec	edent of Hi		in? (Specify Yes of Puerto Rican, etc	r No-	14. Race - A	merican Indian, Vhite, etc.	
9	or Ita		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give			2 <b>∏</b> No	Specify:	i dono moun, oto	•/			
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121	within ene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	III e.								
d 21	filed Hygie ther ant.	ပိ	8th 17. Father's Name (First, Middle, Last)		1		hauff		's Name (First, Mi	ddle. Maid		overnment	
an	ld be ental kad o Ic eva	o Be		Spriggs								i	
Maryland	2 should and Men Is marks sumstic	၉	19a. Informant's Name/Relationship (7	1 00	19b. Mail	ing Addre	ss (Street a	and Number	r or Rural Route N		na Will: vorTown.Stat		
S	lith ar 127 is 1 trau		Rita M. Toogood		1	-			, Ft. Wa				
ē,	as 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hygiene, if item 23 a or 28a-f show item 27 is marked other than "natural", or Itams 23a or 28a-f show rother traumatic evant, the Medical Examinal minit to notified at		20a. Method of Disposition	1	Place of Disp cemetery, cre	osition (N	ame of		Date	-		or Town, State	-
Baltimore,			1 ♣ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		•	-			12/28/200	14	Court 1 m	ed Mo	
alti	permit. Page Department of Important: If any injury or once.		21. Signalure of Funeral Service Ligen	·				s of Facility			eral Ho		
m	Ded and your		I ohn T. St.	Way Ill	/	400	l Ben	ning 1	Kd., N.E.			20019	
	A THE		23a. Part   Enter the disease, or comp shock or heart failure. List only	olications that caused the de	ath. Do not en						William Town	Approximate Interval Between	een.
	Physician		Immediate Sause (Final disease or condition	Sent	<b>1</b>	She	~ K	`				Onset and De	eath
	/Medical		resulting in death)	a Due to (or as a cons	equence of):								
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9 x	eath certificate attending phys i for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of preg	nancy						22d Date of	dolina	
Вох	ath itter or L	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe	tal death 3	⊒Ectopic ⊒ Other (s	pregnancy				23d. Date of Month	Day Ye	ear
0.	D 0 D	ysi	1 ☐ Yes 2 ☐ No 9 ☐ U⊓known	9☐ Unknown			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
ص	requires that the de een signed by the a hould be detached f	y P	Part II. Other significant conditions of	ontributing to death but not re	esulting in the t	underlying	cause give	en in Part I.	23e.	Did tobacc	o use contribut	e to the cause of dea	ath?
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	0 <u>- 0</u>	mc								autopsy performed	death		use of
	iclan: Th certificete ector, pag	a	25. Was case referred to medical					26 Place	of Death (Check of	-/-	Vo 1 1 1	res 2□No	
>		0 8	examiner? 1 □ Yes 2 ②No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 🗆 🗆	Othe	200	sing Home 5		6 Other (S	Specify)	
		-	27. Manner of eath	28a. ate of Injury (Month, Day Year)	28b. Time o	-	28c. Injury Work				jury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
io	Attending F r death. sctor: After by the funer	atio	Natural 5 Pending investigation		ппату	М		Yes 2□N	io				
Division	r Attender death	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, facto	ry, office			on (Street r Town, Sta		Rural Route Numbe	er,
0	tal or	Certification;		3,									
	Hospital 4 hours 7 hours 7 hours 8 hours 8 hours 9 hours 14 hours 15 hours 16 hours 16 hours	edicai		ysician: To the best of my k									
	the the ple	ledi	one)	and manner stated.	Tation and on the					-			
	To To To To	Σ	29b. Signature and title of certifier	VO		2	9c. License	number	212	290.	vate signed (Mi	onth, Day, Year)	
7	(2)		James J	Kyllman	MUS		<b>NO</b>	756	2020	1	7,5516	40	
)	('l)			completed cause of death (It									
_		- 1	Samuel	J. Kleinman,	M.D.	1171	l Liv	vingst	on Rd.	Ft. V	Jash.	MD 20744	
	Sta	to	31. Date filed (Month, Day, Year)	A. Registrar's Sig	nature		_		,				

		1 Decedesta Name (Pt - 1411)				rtificate d		-		eg. No.	U U 14	-3 C -3
hysician	ı	Decedent's Name (First, Middle, La     GEORGE	ist)			SIMMO	NS		2. Date of Dea Month DECEMBE	Day	2004	3. Time of 1:16
Medical/ Examiner		4a. Facility Name (If not institution, give	ve street and numbe	er)		4b. City, Tow	n, or Location		DEGLEBE		County of Deal	
		Prince Georges M	edical Ce	nter		Chev	erly			Pr	ince G	eorges
ıneral			MM alle		last birthday, Yrs.	If Under 1 Ye   Months   Da		er 24 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	9. Birt	thplace (State o
rector		251-42-1490 Usual Residence of Decedent		83	Trs.				May 11	, 19	21 Edge	efíeld,
Mot	-	10a. State 10b. County		10c. Cit	ty, Town or L	ocation						10d. Inside Ci
inter ctor	2	MD Prince	Georges	M:	itche1	ville						1 ⊠ Yes
or 28		10e. Street and Number				10f. Zip Cod			1	0g. Citíz	en of What Co	ountry?
is 23s	5	2112 White Fox ]		at F	6 40	2072		2:::0/0	7		SA	
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Mudical Examiner must be notified at To Be Completed by Funeral Director	3	<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Deceder Armed Force 1 X Yes 2	s?		If Yes, specify C	of Hispanic C Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	1.	4. Race - Ame Black, White	
Exam by	2	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates	11/2	25/194	44 1  Yes 2	No Specif	y:		5	Specify: Bl	lack
of the Medical Fit, the Medical F	מופר	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a, Dece	dent's Usual Oc	cupation	ast of worki	ina	16b. Kin	d of Business/	Industry
han a	3.	Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of work do DO NOT use re	tired)		9			
nt. Et	3	6th.  17. Father's Name (First, Middle, Last	• )		LA	borer	18 Mot	har's Name	(First, Middle, M		. Gover	nment
arked ott atic even To Be	5	Milo Simmons	,						o11oway	naiueri 3	umame)	
mati		19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ing Address (Str			I Route Number,	Cîty or	Town, State, Z	Zip Code)
n 27 ls er tra		Catherine L. John	nson/Daugl	hter	2003910165				itchelyi			
Important: If item 27 any injury or other tr <u>once</u> .		20a. Method of Disposition		20b. P	lace of Dispo	osition (Name of matory or other		0	ate	20c. Loc	ation - City or	Town, State
ury o		1 Donation 5 ☐ Other (Specif		ter i	lar Hi	11 Cemet	tery			Suit	land, M	ſd.
Import any inj once.		21. Signature of Funeral Service Licer	nsee						shall's			
- 6 O	1	J. P. M.	arsha	el_					Washingt		D.C. 2	20011
dical		Immediate Cause (Final disease or condition resulting in death)	α	line.	ALZHE	EMER'S I			r respiratory arre	est,		Approximate Interval Betw Onset and D
ial-transit ial-transit Examiner		disease or condition	Due to (or a	LA OF as a consequate a consequence a consequate a consequence a consequ	ALZHE] uence of): uence of):				r respiratory arre	st,		Interval Betw
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interior: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit and certification: To Be Completed by Physician/Medical Examiner		disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate with the cause of cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Due to (or a b. Due to (or a c. Due to (or a d. d. 23c. If yes, outcome 1 Live birth 4 Pregnant 9 Unknown contributing to death LURE  Hospital: 1 Lipa Inpa 28a. Date of In (Month, D. D. Due to (or a d. d. d. d. d. d. d. d. d. d. d. d. d.	LA OF as a consequence of pregna 2 Fetel at time of did but not resultient 2 pigury yay Year) injury - At hoefic. (Specify	ALZHE] uence of): uenc	DECtopic pregna Other (specify, anderlying cause of 28c. In M 1 1 29c. Lice	26. Place Other: 4 Nork? Yes 2 Cee	I	23e. Did tob  1  Ye  24a. Was ar autopsy perform 1  Yes 2  (Check only one one 5  Resider Red. Describe hor City or Town, and due to the card at the time, da	acco uses s 210  ad? No noe 6 [ w injury ( Stare)  use(s) ar te and pl	Month  a contribute to  No 3   Pro  24b. Were aut prior to c death? 1   Yes  Other (Spec occurred	Interval Betwonset and D  very Day The cause of depotably 4 Unitopsy findings a completion of ca 2 No  ral Route Numb  stated. to the cause(s)

Y LEE SAND	LIX	1 - For Unpersonal State Ragistrar		m 23a,27,2	Maryland 8a T pe	d/Dep er me Ce	artmen G839 rtificate	tof the	ealth an 205 ta Death	d Men	tal Hy	giene Reg. Ne	2001	4	124	s 1 7
Physici	an	1. Decedent's Nam			C -	n d o m	~			N	Date of Dea	Day	y Ye	ar	3. Time <i>o</i> 0730	f Death
/Medic		Gary		Lee		nder		Town or	Location of D		EC.		2004			A M
Examin	ier	5. Social Security N		give street and numb		n në bilath da ci			Location of D				County of D VORCES			
Funeral Director		257-37-	-7292	1. <b>X</b> M 2. F	3.1	Yrs.	Months	Days		Vin. 8. (/	Date of Birt Month, Day 131/	n y, Year) 1973		Country Country		or Foreign
larylanc ehow	ក	10a. State AZ.	10b. County Yavap	ai		Town or L		21/						10d	. Inside C	ity Limits
h the M r 28a-f	Director	10e. Street and Nu					10f. Zip					10g. Citi	izen of What	Country		
th wit	aD	1599 I	East R	oad 2 No	rth		86	6323	3				T	JSA		
Baltimore, Maryland 21215-0036 permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Evantral must be notified at once.	/ Funeral	11. Marital Status		12. Was Deced Armed Force 1  Yas 2 If Yes, Give	es? ? <del>□</del> No	5. 13.		dent of Hi cify Cuba	spanic Origin' n, Mexican, Pi Specify:	? (Specify ) uerto Ricar	Yes or No- n, etc.)		14. Race - A Black, W	merican hite, etc	).	
21215-0036 od within 72 hours alt gjene. er then "neturel", or ine Medicel Exerti	ted by	3 Widowed	15. Decedent's	Year or Dat s Education	es:	16a. Dece	dent's Usua	al Occupa	tion			16b. Ki	Specify:		ite	
1215 within 7 ne. hen "n	Completed	Elementary/Seco		grade completed) College (1-4	4or 5+)				uring most of	working						
d 2.		10 17. Father's Name	(First, Middle, L	ast)		DI	rage	Bul	lder	Name (Firs	st. Middle.		onstri	uct	Lon	
Maryland d 2 should be file th and Mental Hy 77 is marked oth traumatic event	To Be	Billy	Sande:	rs					Garr	y An	n Ar	ıder	son			
Mar nd 2 she lth and 27 is m		19a. Informant's Na Billv S		ip <i>(Type, Print)</i> s/Brothe:	r	19b. Maili	ng Address 9 Eas	(Street a	nd Number of	Rural Rou	te Numbe	r, City o	r Town, Stat	e, <i>Zip C</i> o	ode) 86	323
Baltimore, Normaline Pages 1 and Department of Health mportant: If item 27 nny injury or other trungs.		20a. Method of Disp	position	3 □Removal from St	20b. Pla	ace of Dispo				Date	cii/c		cation - City			1201
t. Pag rtment rtant:		`4 □Donation	5 ☐ Other (Sp	ecity	Che				m. 12,		-		ltsvi			
Balt permit. Departr imports any inj		21. Signature of Fu	neral Service L	will sent the sent th		1	HTLT 241	Pade B	RTWAI umbia	LDI I Blvo	FUNE:	RAL lve:	SERV r Spr	ICE ing	,P.A ,Md2	1. 2091
Wedical Examiner Division and the burial-transit	icai Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list confirm to import to	nditions, imediate riying injury	b. Due to (or	ic(hero r as a conseque r as a conseque	ence of):	d Coca	aine	Intoxi	icatio	on				nset and i	Jeath
P.O. Box 68760, that the death certificate be end by the attending physician detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?		h 2 ☐ Fetal on tat time of dea	death 3[	Ectopic pre					2	23d. Date of Month	delivery Da	y ń	⁄ear
cords, P	by	Part II. Other signif	icant condition	s contributing to dea	th but not resul	ting in the u	nderlying ca	ause give	n in Part I.	_ 2			se ∞ntribute □No 3□			
Vital Reccicion: The law recertificate has be	Completed									-	24a. Was a autops perfor	sy	24b. Were prior t death	to compl	etion of ca	available ause of
on of ding Physics After this funeral din	Certification: To Be	25. Was case referexaminer?  1 X Yes 2 C  27. Manner of Deatt  1 Natural  2 Accident  3 Suicide  4 Homicide	No	ot be led building	Injury Day Year) T Injury T Injury - At hom T Injury - At hom T T T T T T T T T T T T T T T T T T T		f 28	8c. Injury Work	4   Nursin	g H <i>o</i> me :	5 ☐ Reside Describe he	ence 6 ow injury	Mother (S) cocurred d Number or	unk		
Division To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only	1☐ Certifying	Physician: To the b	is of examination	ledge, deat	occurred a	at the time	e, date and pla	Ocea ace, and di	an Ci	ty,	Maryla and manner	and as state	d	
To the within 2 To the complet	Medical	29b. Signature and	title of certifier	and manne	of death (Item 2	23a) (Type,	29c.	. License O.	number C.M.E		2	9d. Date DEC	e signed (Mo	onth, Day	, Year)	
		ZM31. 31. Date filed (Mon.	LICCA	4 AY	11	L1 PEN	IN STR		BALTI	MORE,	MARYI	LAND	21201	_		
Star Registra		0		2005	gistrar's Signatu	K A	men!	,								

			For State	State of Maryland		artment of		and Me		ene g. N2 0 0	4 121.18	
			Registrar  1. Decedent's Name (First, Middle, Last)		001	incate of	Dealit	2	. Date of Death	1	3. Time of Death	_
	Physici		Jeff S	Swinebroad				D	Month December	Day 21, 20	Year 004 3:15 A. M	
	/Medic Examir		4a. Facility Name (If not institution, give :			4b. City, Town,	or Location of			4c. County o		
			10423 Kardwright Co			Montgom					gomery	
	Funeral		5. Social Security Number 6. Sex	TM 2DE	ast birthday) Yrs.	If Under 1 Yea Months Day		Min.	Date of Birth (Month, Day, [arch 22]	Year)	Birthplace (State or Foreign Country)  The Country	I
- 2	Director		521-34-0422 Usual Residence of Decedent	77	113.			N	arch 22	1927	TN	_
	yland Now		10a. State 10b. County	10c. City	, Town or Lo	ecation					10d. Inside City Limits	
	a-fst	io	Maryland Montgome:	ry Mo	ontgom	ery Vill	age				1 ☐ Yes 2X No	_
	or 28	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of Wh	nat Country?	
	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Items 23a or 28a-f show ont, the Mcdical Examirer must be nutified at	ra l	10423 Kardwright Co		0 100		0886	-:-0 (0:	4V	USA	- American fndian,	_
	er de Items	Funeral	11. Marital Status  1 ☐ Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No	S. 13.	Was Decedent of If Yes, specify Cu	iban, Mexican	gin? (Speci n, Puerto Ri	ty Yes of No- can, etc.)		, White, etc.	
39	urs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ N	o Specify:			Specify:	White	
Ö	2 hou		15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occ kind of work don	upation	t of working		6b. Kind of Bus		_
2	ifhin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retii	red)	t or working			_	
7	led wi lygien her th			5+	Ac	lministr		ria Nama /		ederal Jaiden Sumame	Government	
Maryland 21215-0036	ntal H ed otl	Be	17. Father's Name (First, Middle, Last)  Jefferson	Davis Swine	broad		18. Mothe		Dorothy	Bus	_	
Ž	should ind Men i marke umatic	2	19a. Informant's Name/Relationship (Ty			ng Address (Stre	et and Numbe					-
<u>8</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be nullified at ance.		Jean L. Swinebroad								age, MD.20886	
ē,	s 1 ar if Hea item othe		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other p		Dat		-	City or Town, State	_
Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 🖾 Cremation 3 ☐ F  1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State			.	12/21	/2004 A	lexandı	ria, Virginia	
a	permit. Departmin importa eny inju		21. Signature of Funeral Service Licens		22	2. Name and Add	ress of Facilit	y DeVo	1 Funer	al Home	9	
<u>~</u>	89E 2 9		Medeal	/ Level	سراه	East De	eer Par	k Dr.	, Gaith	nersburg	g, MD. 20877	_
F.	Physician /Medical Examiner	)r	23a. Part 1. Enter the disease, or compl shock, or heert failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Coronary Art Due to (or as a consequence)  Ventricular Due to for as a consequence Due to for as a consequence Due to for as a consequence	tery D Jence of): Fibri	isease	ying, ducit as		ospitatory are	J.,	Approximate Interval Between Onset and Death	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury	c.  Due to (or as a consequence)	uence of):							
.O. Box 6	that the death certific ed by the attending pi detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do 9 Unknown	death 3	Ectopic pregnar Other (specify)				23d. Date Mont	of delivery h Day Year	
ds, P		by	Part II. Other significant conditions con	ntributing to death but not rest	ulting in the u	nderlying cause (	given in Part I.				oute to the cause of death?  B Probably 4 Unknown	
Records,	The law requires ate has been sign page 2 should be	Completed							24a. Was an autopsy perform	ed? de	ere autopsy findings available for to completion of cause of eath?	-
Vital	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical				26. Place	of Death /	1 ☐ Yes 2 Check only one		Yes 2 No	_
	Physician: this certifical director.	0 8	examiner?	Hospitaf: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	)ther			nce 6 Other	(Specify)	
J Of		n: T	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		jury at lork?	28	d. Describe how	w injury occurre	d	
Sior	Attending Phradening P	atic	2 Accident investigation		,- ,	M 1	□Yes 2□	No				
Division	or At fiter of Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, offic	е	28	f. Location (Str. City or Town,		r or Rural Route Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		sicien: To the best of my kno iner: On the basis of examina and manner stated.								
	To the To the Comp	Σ	29b. Signature and title of certifier		ν γ	29c. Lice	nse number		29		(Month, Day, Year)	
	6		<u> </u>	www		D	51280			12-	-21-07	
	· ·		30. Name and address of person who co				D.	C11+ + ~	#2∩1	Pockui 1	16 MD 20850	
6	Sta	1	Anushiravan Dadgar	32. Registrar's Signa		*		parce	7F Z U I 9	NOCKVII	те, ты. 20000	-
	- 51		DEC 99 20	1011 Denevas		Soon	02/					

			4 (0)	partment of Health and Mental Fertificate of Death	Hygiene	10
H	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Month	Death 3. Time of D	
	/Medic Examin		GARY MICHAEL SHUKEN  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	/2004 3:30 A 4c. County of Death	
£		e e	CASEY HOUSE	ROCKVILLE	MONTGOMERY	
	. Funeral Director		5. Social Security Number  578-66-5810  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  Yrs.	y If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month, 11/22	Birth 9. Birthplace (State or In Country)  / 1948 WASHINGTON	Foreign
	ō		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le			
	Maryla	tor			10d. Inside City 1 ∐ Yes 2	
	or 28a-	irec	10e. Street and Number	LVER SPRING  10f. Zip Code	10g. Citizen of What Country?	
	ath wil	raiD	3310 NORTH LEISURE WORLD BLVD #916	20906	U.S.A.	
·0	fter de r Item inern	Funeral Directo	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.	
5-0036	be filed within 72 hours after death with the Manyland tall Hygiene. do ther than "natural", or flems 236 or 28a-f show event, the Medical Eraniner must be notified.	by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🙀 No Specify:	Specify: WHITE	
2	in 72 h	piete	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry	,
212	ad with rgiene er thau	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 BUSIN	ESS OWNER	PAPER	
Maryland 2121	a - 0 =	Be	17. Father's Name (First, Middle, Last) GEORGE SHUKEN	18. Mother's Name (First, Mid MARY	dle, Maiden Sumame) TEITELBAUM	
ar Z	should ind Men ind marke in marke	To		ing Address (Street and Number or Rural Route Nu		-
	and 2 ealth a n 27 is			REDWOOD STREET, SAN DI	EGO, CALIFORNIA 92104	4
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evense.		1 1 2 Dutial 2 Distribution 3 Symptomic Value 110111 State	osition (Name of Date amatory or other place)	20c, Location - City or Town, State	
altin	permit. Pa Departmen Important any injury			ID MEML GDNS 12/17/2004 2. Name and Address of Facility DWARD SAGEL FUNERAL DIR		
m —	Per L		10	091 ROCKVILLE PIKE, ROCK	KVILLE, MARYLAND 208	52
P			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Betwee Onset and De.	
į	Physician /Medical	90. 19	Immediate Cause (Final disease or condition resulting in death)  METASTATIC PANCR Due to (or as a consequence of):	EATIC ADENOCARCINOMA		
	Examiner					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
ó	ate be executed hysician and the burial-transit	Ехаг	that initiated events c. Due to (or as a consequence of):			
8760	reate be executed physician and s the burial-transit	dicai	d			
9 xo	death certificate attending place as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- 1 2 2	23d. Date of delivery	
Ö.		Physician/Me	in the past 12 months?  1 Yes 2 No  1 Ves 2 No	□Ectopic pregnancy □ Other (specify)	Month Day Yea	ar
<u>a</u> .	by tac		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. D	id tobacco use contribute to the cause of dea	ath?
rds	w requires that been signed should be det	ed by	1	1	□Yes 2□No 3□Probably 4ӁUnk	known
Vital Records,	e law requ has been je 2 shouk	Completed		24a. W	utopsy prior to completion of cause	ailable se of
<u>m</u>				1 □ Ye	orformed? death? s 2 ☑ No 1 ☐ Yes 2 ☐ No	
	ysician: iis certifica director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatier	26. Place of Death (Check on onto 3 DOA Other: 4 Nursing Home 5 R	<i>lv one)</i> esidence 6X00ther <i>(Specify)</i> HOSPIC	TE.
0 0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at 28d. Descrit Work?	be how injury occurred	,11
Division of	after death.  Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm, str	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Locatio	n (Street and Number or Rural Route Numbe	or,
á	talor Arsatter al Direc ed in by	Certi	4 Homicide determined building, etc. (Specify)	City or	Town, State)	
	To the Hospital or Attending Physician: within 12 4 hours safter death and 12 to the Funeral Director: After this certifical completely filled in by the funeral director,	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat  Check only one)  Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to to the timestigation, in my opinion, death occurred at the times.	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)	
	To t Withi To t	Ž	29b. Signature and tibe of penifier	29c. License number	29d. Date signed (Month, Day, Year)	
1	V		30. Name and address of person who completed cause of death (Item 23a) (Type,	D41218	12/16/04	
_	25		DR. CHARLES HARRISON 6001 MUNCASTER N	MILL ROAD, ROCKVILLE, MI	20852	
	Sta Registr		DEC 22 2004  32 Registrar's Signature	Sporks		

			1 - For Stata Registrar	State of Ma		artment of Healt		ental Hygie	2001	42420
ľ	Physici		Decedent's Name (First, Middle, La  Frank	willian		ımmers		2. Date of Death Month	Day Yea 19, 200	3. Time of Death
)   87	/Medio Examir		4a. Facility Name (If not institution, given			4b. City, Town, or Local		December	4c. County of De	
	Funeral Director		-	Sex 7. Age 1 ☑ M 2 ☐ F	e (In yrs. last birthday) 71 Yrs.	If Under 1 Year If Un Months Days Hou	urs Min.	8. Date of Birth April Day Ye	9. E	lirthplace (State or Foreign Country) ndiana
	Maryland I show fied at	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo Washingt					10d. Inside City Limits 1 (XYes 2 □ No
	h with the	al Director	10e. Street and Number 3330 E Street S	.E.		10f. Zip Code 20019		10g.	Citizen of What U.S.A.	Country?
9036	be filed within 72 hours after death with the Maryland hat Hygiene.  Id thygiene.  If the Maclical Exertiner must be notified at event, the Maclical Exertiner must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 17 Yes 2 1 17 Yes, Give Year or Dates:		Was Decedent of Hispani If Yes, specify Cuban, Me: 1 ☐ Yes 2 ☑ No Spe	c Origin? (Spec xican, Puerto R ecify:	cify Yes or No- lican, etc.)	14. Race - Ar Black, Wi Specify: B	
Maryland 21215-0036	filed within 72 h Hygiene. Ither than "netu ent, Ire Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupation kind of work done during DO NOT use retired) IMPUS Securi		g	. Kind of Busines	
/land	thould be filed and Mental Hygistem marked other matic event, III	To Be C	17. Father's Name (First, Middle, Last Frank	Summers		18. M	Naomi	(First, Middle, Maid B1al		
	nd 2 shallth and 27 Is m		19a. Informant's Name/Relationship Michie Summers		19b. Maili 333	ng Address <i>(Street and Ni</i> 30 E. Street	SE Was	hington l	ty or Town, State DC 20019	, Zip Code)
Baltimore,	permit. Pages 1 av Department of Hea Important: If item any injury or othe 20028.		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Special Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Con		Lee Crem	matory or other place) atory	Dec. Dec. 2004	C1	Location - City o	Maryland
Ball	permit. Depart Import any in		21. Signature of Funeral Service Lice	n cultic	1435100		exandri	a Ferry l		nc. nton, MD20735
	/Medical Examiner bhysician and the burial-transit the burial-transit	Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	a Due to (or as b Due to (or as c	<u>ne</u> .			Tooling and the second		Approximate Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be the has been signed by the attending physic age 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ري ص	quires that n signed by	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause given in P	art I.			to the cause of death?  Probably 4 **Unknown
Vital Record		e Completed	25. Was case referred to medical					24a. Was an autopsy performed 1 Yes 2.2	? prior to	autopsy findings available completion of cause of section 22 No
Division of Vil	ling Phys	ertification; To Be	examiner? 1	28a. Date of Injur (Month, Day	nt 2 ER/Outpatier ry 28b. Time o	nt 3 DOA Other: 4	Nursing Hom	(Check only one) e 5 ☐ Residence dd. Describe how in		vecify)
DİXİ	itel or Attend irs after death rel Director: , led in by the f	O	3 Suicide 6 Could not be determined		ury - At home, farm, str c. (Specify)	eet, factory, office	28	3f. Location (Street City or Town, St	and Number or I ate)	Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in E	Medical	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	h occurred at the time, dat vestigation, in my opinion,	death occurred	d at the time, date	and place, and du	ue to the cause(s)
į	wit To	-	29b. Signature and title of certifier  Mullil	Putiles	00	29c. License numb			Date signed (Moi	4,2004
The state of the s	B DE		30. Name and address of person who	el, 00 601	POST DEF	ICE NOAD !	n wa	LNONE M	IAKTLAI	Up 20002
1	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 2	32. (egistra	ar's Signatur	partie				

State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Ам REED RUSSELL STAMMER Jr December 19, 2004 1:03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Frederick calvert Calvert Memorial Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1**₩** 2□F Days Hours 60 275-40-3874 Director AUG 9, 1944 Arkansas Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 7 ia marked othar than "natural", or Itama 23a or 28a-f show traumatic evant, tre Medical Examinat must be notilled at 10d. Inside City Limits 1 ☐ Yes 2 No Charlotte Hall Maryland St Mary's Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20622 29449 Charlotte Hall Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after I XYes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White à If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 ia marked other than any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vivian Hickson Reed R. Stammer Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda G. Stammer (Wife) 3004 Gallery Place #14 Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Dopation 5 □ Other (Specify) Maryland Veterans Cem 12-27-04 Cheltenham, MD 21. Signature of Juneral Service License 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls. La. White Pls., MD 20695 rener 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician youth ymphoma disease or condition resulting in death) /Medical Due to (or as a c **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Doth 1 (Natural 2 () Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After tha Hospital or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To tha Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 59061 who completed cause of death (Item 23a) (Type, Print) Rd, Ske ZIZ Prive Exelencis, mo 2017 Polel 110 HospiTal

DHMH 17 Rev 1/200

State

Registrar

32. Resistrar's Signature

2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1 Decedent's Name /First Middle Last) 2 Date of Death **Physician** DECEMBER 23, 2004 ROBERT JEROME SMITH 6:23 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5007 WHEELER ROAD OXON HILL PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MAY 19, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□ F 1934 70 MARYLAND 214-28-9634 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show rel', or items 23e or 28a-f shov Exerting must be notified at 1 ☐ Yes 2 ☐ No Director OXON HILL MD PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5007 WHEELER ROAD 20745 UNITED STATES permit. Pages 1 and 2 should be filed within 72 hours after death <sup>1</sup> Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "neturel" or Hame 3<sup>a</sup> Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No 1958 Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DRIVER / FLOWER WORKER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN SMITH MARY ZENOBIA HAWKINS SMITH ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY J. SMITH / WIFE 5007 WHEELER ROAD, OXON HILL, MARYLAND 20745 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM DEC. 30, 2004 SUITLAND, MD 21. Signature of Funeral Service Licenses Online

LYDIA C. THORNION JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 22. Name and Address of Facility any ii Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARENO MA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 2 X No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sesidence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death • Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the of certifier 29b. Signature and 2 30. Name ss of person who completed cause of death (Item 23a) (Type, Print) of #103 TT. Washingto and add Mi) State 2004

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. ZUUL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** December 21, Barbara Ellen Sites 12:58 p M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. Nonth, Day, Year Dec. 23, 1957 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛱 F Maryland 190-50-3264 46 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f ehow other treumatic event, the Medical Exeminer must be notified at 1⊠Yes 2 No Cecil Rising Sun Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 156 South Queen Street, P.O. Box 243 21911 U.S.A. or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates White "neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within to f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence Ten Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Kennedy Versia May Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Randy W. Sites (Husband) P.O. Box 243, Rising Sun, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department c Importent: If any injury or once. Conowingo Baptist 12/27/94 4 ☐ Donation 5 ☐ Other (Specify) Conowingo, Maryland Church Cemetery
22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service License Or. 21903-0766 Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Dinker 21 /Medical Due to (or as a consequence of): **Examiner** 

Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

Physician/Medicai

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Completed

Be

Certification: To

NEWMOUSE Due to for as a consequence of Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 XNo

9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 No 1 ☐ Yes

25. Was case referred to medical examiner? Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA 1 Tes 27. Manner of Death Natural 5 Pending investigation 2 Accident 6 Could not be

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jo Khadar

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

281 E. Main

Hospitel or Attending Physicien: The law requires that the death certificate be executed

death.

Director:

within 24 hours a To the Funerel (

filled in by

funeral director, page 2 should be

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T	Funeral		5. Social Security Number		7. Age (In yrs. Is		If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of I	Birth Day, Y	ear)	9. Birthr	place (State or Fo	oreign
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Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationsh Sister Camilla				-				<i>i Route Nur</i> E <b>mmi</b> ts		City or Town,	State, Zip 217	`	
<u>.</u>	Healt Healt tem 2 other		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nan	ne of	1		ate	-	c. Location -			
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ı	with To t	M	29b. Signature and title of certifier	Alla	Ca	usli	W) 290	. License	number 187	05			Date signed			
			30. Name and address of person		e of death (Item	23а) (Туре,		•				-				
	Sta	te	ALAN CARROLL, 31. Date filed (Month, Day Mar)		0 S SE' egistrar's Signat	TON AV	E E	TIMM	SBURG	, MD	. 2172	2.7				
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			Registrar  1. Decedent's Name (First, Middle, Last)	<i></i>	runcate of Death	2. Date of Deat	eg. No:	3. Time of Death
	Physicia		Wilmer Alfred	Stewart		Month	Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and no		4b. City, Town, or Location of D	DECEMBE Death	4c. County of Dea	
			MEMORIAL HOSPITAL		CUMBERLAND		ALLEGA	NY
	Funeral		5. Social Security Number 6. Sex 1 ★ M 2 □ F	7. Age (In yrs. last birthday) Yrs.		Hrs. 8. Date of Birth Min. (Month, Pay, Aug 12,	Year) 9. Bir	thplace (State or Foreign ountry)
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∑ 	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I them 23a or 28a-f show them 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examination in a file of the modified at				Sylvan Avenue	Cumbe		D 21502
0	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or othar tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from		natory or other place)	1/3/2005	20c. Location - City or	
Бант	it. Pa artmer ortant: njury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Auneral Service Licensee</li> </ul>	Hillcrest Me			Cumberlan	d MD
מ	Departing Department on in once.		* Admin	Solli"	2. Name and Address of Facility Scarpelli Funeral			00
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7	that the		Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	ures n sign lid be	d b	ALZHEIMERS, CORONARY AR			1 ☐ Ye	s 2 No 3 P	robably 4 MUnknown
000	s beel	olete				24a. Was ar	24b. Were a	utopsy findings available completion of cause of
ב ב	sician: The law requires that the death certifical certificals been signed by the attending phy lirector, page 2 should be detached for use as the	Completed by				— autopsy perform	ned?   death?	completion of cause of 2 □ No
	tan: irtifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of	Death (Check only on		20.10
> i	hysic his ce al dire	인	1 ☐ Yes 2X No Hospital: 1X	Inpatient 2 ER/Outpatier		ng Home 5 ☐ Reside		cify)
	After 1	ion:	1 Activatoral 3   i briding	of Injury onth, Day Year) 28b. Time of Injury	Work?	28d. Describe ho	w injury occurred	
DIVISION	death death ctor: , the t	licat	2 Accident investigation 3 Suicide 6 Could not be 28e Plac	e of Injury - At home, farm, str	M 1 Yes 2 No	28f. Location /Str	eet and Number or R	ural Route Number.
<u> </u>	after after Dira	Certification:	4 Homicide determined build	ding, etc. (Specify)	eer, ractory, onice	City or Town	State)	graff found from S. j
2	To the Hospital or Atlanding Physician: The I within 24 hours after death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier  (Check only  2 Medicel Examiner: On the	e best of my knowledge, death	n occurred at the time, date and p	lace, and due to the ca	use(s) and manner as	s stated.
	the H nin 24 the Fi	ledical	one) and ma	hasis of examination and/or in	vestigation, in my opinion, death o			
ı	To	Σ	29b. Signature and title of centifier	Then	29c. License number	29	d. Date signed (Mont Dec 31-	h. Day, Year)
			[V /) (=0)		D19318		JKC 3/3	1669
	6		30. Name and address of person who completed cau DR. N.A. RANJITHAN, 517	4	CUMBERLAND, MD	21502		
	Sta	te	04 D 1 (1 1 (14 1 ) D 14 1			2.302		
	Registr		JAN 1 0 2005 Acres	Hegistrar's Signature				

			1 - For State Registrar	State of Marylar	nd / Depa	artment of	Health and	Mental Hy	giene2 0 0 4	42426
	Physici /Medic	cal	Decedent's Name (First, Middle, La. DOROTHY  4a. Facility Name (If not institution, giv.)		SZYMAN		a or Location of Do		21 2004 ear	3. Time of Death 01:42P M
	Examir Funeral	ier	Univ. of Mary  5. Social Security Number 6. S	land Medica ex 7. Age (In yrs.	last birthday)	Bald  If Under 1 Ye  Months Da		s. 8. Date of Bir	4c. County of Deat  Baltimo  th ay, Year)  9. Birti Co	
	Director work		Usual Residence of Decedent  10a. State 10b. County	10c. C	Yrs. ity, Town or Lo	cation		August	2, 1914	PA  10d. Inside City Limits
	vith the Ma or 28a-f s te ne lifter	Directo	MD Ceci  10e. Street and Number		hesape	ake C:	9		10g. Citizen of What Co	1 □ Yes 2√2 No ountry?
9036	72 hours after death with the Maryland 'natural', or Itams 23e or 28e-f show dies! Exercine must be netified at	d by Funeral Director	#55 Country R  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		∐Yes 252th	of Hispanic Origin? ( tuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No rto Rican, etc.)	U • S • A •  14. Race - Ame Black, White  Specify: Wh	e, etc.
1215-	within 8ne. than "	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed)  College (1-4or 5+)	(Give life. L	lent's Usual Ockind of work do. 20 NOT use rel	cupation ne during most of w iired)	orking	16b. Kind of Business/ Househol	·
Maryland 21215-0036	be filed ital Hyg id othe avant,	To Be Co	17. Father's Name (First, Middle, Last) Anthony Szczu		TOMO	Mana		ame (First, Middle,	, Maiden Sumame)	
	ss 1 and 2 and 4 and 4 and 1 a		19a. Informant's Name/Relationship (  Mary Ann Rees  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	e/Daughter	#55 Place of Dispo cemetery, cren	Count	ery Rd.,	Chesar Dat 27,20	er, City or Town, State, 2 Deake City	MD 2191! Town, State
Baltimore,	permit. Page Department Important: If any injury o		4 □ Donation 5 ☒ Other (Specification of Funeral Service Licer	entombment	22 <b>A</b>	. Name and Ad	Cemetery dress of Facility G. Gee	Funea1		
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deal one cause on each line.  a. Closed Heal Due to (or as a consecutive content of the content of	d Inju		dying, such as cardia	ac of respiratory a	rrest, MD 2	pro imate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and for use as the burial transit	icai Examiner	Sequentially list conditions, It any, leading to limited data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Respirato Due to (or se a consec  Aspiratio Due to (or as a consec  d.	quaries of): n	lure		L'.MC		
.O. Box 6	the y th iche	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 6 9 Unknown	al death 3	Ectopic pregna Other (specify)			23d. Date of delined Month	very Day Year
ecords, P.	ires tha signed d be de	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	derlying cause	given in Part I.		obacco use contribute to Yes 2 🛣 No 3 🗌 Pro	
$\infty$	The ate has page	Completed						24a. Was autop perfo 1 - Yes	prior to c rmed? death?	topsy findings available completion of cause of
of Vital	Physician: Th r this certificate rral director, pag	: To Be	25. Was case referred to medical examiner?  1\( \begin{align*} \text{Yes} & 2 \cup \text{No} \end{align*} \)  27. Manner of Death		¥R/Outpatien 28b. Time of	1 3 □ DOA 28c. In	Other: 4 Nursing		nne)  dence 6 □Other (Spectors)	rify)
Division	il or Attanding i after death. I Diractor: After d in by the funer	Certification:	1  Natural 5  Pending  2  Accident investigation 3  Suicide 6  Could not be 4  Homicide determined		10:30	) M 1	njury at Vork? □Yes 2 📉 No ce	Fal	.1 Street and Number or Bu	ral Route Number,
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medicai Cer	(Check only 2 Medicel Exan	ysician: To the best of my known in er: On the basis of examination	owledge, death	occurred at the	time, date and place	e, and due to the	Sate of the same o	stated.
)	To the within 2 To tha comple	Mec	29b. Signature and the of certifier	and manner stated.		29c. Lice 162	ense number 74		29d. Date signed (Month	
	7		30. Name a dress of person who Jay w. Meyer,	12		St. Ba	ltimore,	Md 212	01	
	Sta Registr		31. Date filed (Manth Day Year) 201	Registrar's Sign	ture	de la				

			. For	State of Mary		artment of F		nental Hygid	ene	1010=	
			1 - State Registrar		Ce	rtificate of	Death		1. No. 004	42427	
	Physicia	an	1. Decedent's Name (First, Middle, Last) Foday Sheriff					2. Date of Death Month December	Day 2004	3. Time of Death 4:40 p M	
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death	<u> </u>			
			Laurel Regional	Hospital		Laure			Prince Geo	orges	
	Funeral Director		5. Social Security Number 6. Sex 219-25-7870		yrs. last birthday 40 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	<sup>9. Birth</sup> 1964 Sier	place (State or Foreign ntry) ra Leone, WA	
	and W		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits	
	Maryl -f sho fied a	tor	MD Prince G		Lanham					XXYes 2 □ No	
	th the	lrec	10e. Street and Number	0		10f. Zip Code		100	. Citizen of What Cou	ntry?	
	ath wi	ral	9977 Goodluck Rd.			20706			USA		
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, it a Medical Examinar must be notilised at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:		
9500-61212	"natura	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Deci (Giv	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work	ing 16	6b. Kind of Business/la	ndustry	
717	withir iene. r than	omp	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	me.		" ınagement		Priva	te	
פַ	e filed al Hyg other vent.	BeC	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)		
<u>Xa</u>	ould b Mentz arkad atic e	ToE	Mohammed Sheriff					Sheriff			
Maryland	d 2 sh thand 7 is m traum		19a. Informant's Name/Relationship (Ty) Terry Sheriff/ Wife			ing Address (Street  Goodluck			City or Town, State, Zi, 20706	o Code)	
<u>၈</u>	s 1 an f Heal item 2 other		20a. Method of Disposition	20		osition (Name of ematory or other place			c. Location - City or T	own, State	
Ē	Page nent o ent: If ury or		1					6/2004 A	delphi, Ma	ryland	
Baltimore,	ermit. Pepartr nporte ny int		21. Signature of Funeral Service/License	99/		22. Name and Addre			ins Funera		
	20 E e d		23a. Part1. Enter the disease, or compli	cations that caused the		474 Lando				5 Approximate	
	กระเวลก		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		ırrythmia	3,		"	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a con		птусишта					
	Examiner	_	Sequentially list conditions,	Seps:							
	pet usit	nlne	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a con Rena.	nsequence or): 1 Failur	e					
o Î	ate be executed hysician and the burlal-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
	ate be hysicia the bu	lcal		l							
R9 X	certific Iding p	/Med	IF FEMALE:	3c. If yes, outcome of pr	regnancy				23d. Date of deliv	en	
O. Box	that the death certifica led by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1						Month Day Year		
ري ح	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?	
rds	w requires to been signer should be		Coagulopathy					1 ☐ Yes	2□No 3□Pro	bably 4XIUnknown	
Kecords,		ompleted	Liver Failure					24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of	
_	eician: The law certificate has t irector, page 2 s	O	Small Bowel Obs	truction				performe 1 □ Yes 2X	No 1 ☐ Yes	2 No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	2 ☐ ER/Outpatie	ort 30 DOA Oth		h (Check only one)	ce 6 □Other (Speci	60	
	ding Phy h. After this funeral d		27. Manner of Death	28a. Date of Injury (Month, Day Yea			y at k?	28d. Describe how		97	
S	r Attending er death. rector: After by the funer	catlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation			M 1 🗆	1 Yes 2 No				
DIVISION	7 5 5 6	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Stre City or Town, :	et and Number or Run State)	al Route Number,	
	To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical		sician: To the best of my ner: On the basis of exa and manner stated.							
	To the vithin 2 To the complet	Ž	29b. Signature and title of certifier  SHUG M	O AHCA	Ang	29c. Licens D42			Date signed (Month, ecember 20		
10-	(1)		30. Name and address of person who co	·		•					
1	Sta	to-	P.S. Aujla MD., 31. Date filed (Month, Day, Year)	5632 Annapo	Signature		, Bladens	burg, MD	20710		
	Sta	ite .	27 2004		k L	200					

DHMH 17 Rev 1/2001

Shoulf Poelay. 5-11-64. Mr Soum, 111

			1 - For State Registrar	State of I	Marylaı		artment rtificate			nd M		giene	04	42428
	Dhusiai		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea	ath Day	Yeer	3. Time of Death
	Physici /Medio		Joyce Ann Thom	as							Decembe	er 25,	2004	6:50 A. M
	Examin	ier	4a. Fecility Name (If not institution, giv		er)		,		Location of	Death		4c. Co	unty of Death	1
			4411 Rena Road  5. Social Security Number 6. S		Ann Univers	Jana Milatratoria	Su:	itla	nd If Under 2	4 Ura				eorge's
	Funeral Director				55 (in yis	. last birthday) Yrs.	Months	Days	Hours	Min,	8. Date of Birth (Month, Day 2/2/49	n /, Year)	9. Birth	nplace (State or Foreign untry)
			Usual Residence of Decedent								2/2/49		Cne	verly,Md.
	nylan how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	e Ma Sa-f s	cto	Md. P.G.			Suit	land							1√2 Yes 2 □ No
	ith th	Director	10e. Street and Number				10f. Zip (	Code				10g. Citizer	of What Cou	untry?
	8 238	rai	4411 Rena Road #			10 10			2074				J.S.A.	
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or itams 23a or 28a-f show matic event. Ira Medical Examinat natal be rediffed at	by Funerai	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2[ If Yes, Give Year or Date	s? <b>X</b> No		Was Decede f Yes, speci 1 ☐ Yes 2	3.7	spanic Origi , Mexican, Specify:	in? (Spe Puerto f	cify Yes or No- Rican, etc.)		Race - Amer Black, White ecify: B.	
Š	2 hou		15. Decedent's E	ducation		16a. Deced	dent's Usual	Occupa	tion			16b. Kind	of Business/Ir	ndustry
215	hin 7. 9. Bn "n	Completed	(Specify only highest gra	de completed) College (1-4d	or 5+)	(Give	kind of work DO NOT use	done di retired)	uring most o	of workin	ng			,
7	er th	Con		2 yrs.		Loan	Offic	er/A	sst.	V. I	Preside	nt Bar	nk	
В	be filed ital Hygi id other event.	Be	17. Father's Name (First, Middle, Last)								(First, Middle,			
3	should ind Men marka umatic	٢	Kermit P. Harrod	Euro Deied		400 14 70		(2)			te R.			
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relationship ( Charles Edward Th		band						Route Numbe Suitland			
ē,	Heal Heal tam 2		20a. Method of Disposition		20b.	Place of Dispo	sition (Name	e of			ate		on - City or T	
ē	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or other tra once.		1 Burial 2 Cremation 3 C 4 Donation 5 Dther (Specific	Removal from Sta		cemetery, cren esameak				nc 1	2/29/04			
턡	mit. F partma portar injur		21. Signature of Furneral Service Lice		) CII									
ä	De de la company		160	UNIO,	5%	4	925 Bi	ishii irrol	ngton ughs 1	& So Ave.	ons Co. ,N.E.,W	Inc. ashin	gton.D	.C. 20019
			23a Pert1. Enter the disease, or com shock, or heart failure. List only	neations that caus	sed the dea	th. Do not ente	er the mode	of dying	such as ca	ardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			of Brea								Onset and Death  2 yrs.
	/Medical Examiner		resulting in death)		as a consec				-					L JID.
	Lxammer	_	Sequentially list conditions,	b										
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Dua to (on	35-6-000590	quence ory:								
	al-trau	xan	that initiated events resulting in death) Last	c Due to (or a	as a consec	quence of):	-						-	
8760,	icate be executed physician and s the burial-transit	dicai E		d									i	
99	rtificat ng phy as the	ledic		. 0.										
Box	The law requires that the death certific sie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre	onancy				23d.	Date of deliv	,
H	e deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant 9☐Unknown	at time of o		Other (spe						Month	Day Year
P.O.	d by t	Phy	9 Unknown								Last Silver			
JS,	signe d be d	5	Part II. Other significent conditions c  Chronic Rheumato			suiting in the ur	ngeriying çai	use giver	in Parti.					he cause of death?
Ö.	w requir been si should I	etec	_ CHOILE MEMBER	nu Alun	TCTS					_			No 3 Probably 4 Unknown	
æ	has pe 2 s	Completed					_	24a. Was a autops	SV.	lb. Were auto prior to co death?	opsy findings available empletion of cause of			
<u> </u>	n: Th ficate or, pa		25. Was case referred to medical								1 ☐ Yes	2 No	1 ☐ Yes	2 No
5	Physicien: r this certifica ral director,	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 2	] ER/Outpatient	3 DOA	Other			Check on on		Other (Seesil	-
ō	g Phy erthi	Ë	27. Manner of Death	28a. Date of Ir (Month, L		28b. Time of		c. Injury : Work?			8d. Describe ho			(y)
0	Attending r death. actor: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	Jay (Bai)	injury	М		s 2 □ No	0				
Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of i	Injury - At h	ome, farm, stre	et, factory,	office		28	8f. Location (St City or Town	reet and Nu	mber or Rura	al Route Number,
	ral D													
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the be- niner: On the basis	of examina	owledge, death ation and/or inv	occurred at restigation, i	the time n my opi	, date and nion, death	place, ar occurre	nd due to the ca d at the time, d	ause(s) and ate and plac	manner as s ce, and due to	stated. the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner	stateu.	·	29c.	License	number		2	9d. Date sig	ned (Month,	Day, Year)
	⊢s⊢ō		MA	~~~			7	DOS	130	61			-27-	4
R	,		30. Name and address of person who	completed cause of	f death (iter	n 23a) (Type. I			1 -0	96		100	~ /	
1			Azher Hussain, N		,		,	Col 1	eae P:	ark	Md. 20	740		
	Sta		31. Date filed (Month, Day, Year)	2. Regis	strar's Signa	ature					inte 60	<del>/1</del> U		
	Registr	ar	DFC 2 % 2004	Mary	J 18	hou								

For		State of Marylar	nd / Department of Health and N	Mental Hygiene	1 0 1
State Amend	Item	1&10a-f&Unpend	nd / Department of Health and N Item <i>23m227e p#10.eath</i> 6839	1-14-05 No. UU4	424

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Truitt, Jr. Harry Preston 12:40 P M December 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Washington 8. Date of Birth (Month, Day, Year) Dec. 3, 1945 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2□ F Maryland 59 Yrs. 162 36 3729 Dec. Director Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County , or iteme 23a or 28e-f show the Medical Examiner must be notified at Berkeley Springs Warfordsburg ₩ PA -Morgan Fulton 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? -63 Susan Tor 177 Kerns Lane <del>+25411</del> 17267 U.S.A. filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status YTYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. White Specify: þ 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Surveyor Surveying other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mentel F is marked of . Pages 1 and 2 should be tment of Heelth and Mente tent: if item 27 is marked Preston Truitt, Sr. Not available 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon L. Kerns, Jr./Step-son 63 Susan Ter, Berkeley Springs, WV 25411 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Depertment of Importent: if it any injury or or 1 Burial XXCremation 3 Removal from State
4 Donation 5 Other (Specify) Hagerstown Crematory Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Helsley-Johnson Funeral Home, Inc. M00522 95 Union St., Berkeley Springs, WV 25411-1855 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Arteriosclerotic cardiovascular disease /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: esn. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Tetal death 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed рееп 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an autopsy berformed? certificate Yes 2 No the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerel C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) re and title of certifier 29b O.C.M.E. December 7, 2004

State Registrar 30 Name and address of person who co

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31. Date filed (Month, Day, Year)

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2005

111 Penn Street, Baltimore, Maryland, 21201

pleted cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Reg. No. UU L Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marie Ann Usher 6:34 P. M December 11, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12313 Treetop Drive; Apt. 34 Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🗙 F 579-64-6405 55 Director January 5,1949 Washington,DC Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Modical Examiner must be notified at Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23s or 12313 Treetop Drive; Apt. 34 20904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: **Black** þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S.Agency for Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) International 12th grade **Human Resources Assistant** Development 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be finand Mental Hismarked ot John Sylvester Usher, Sr. ပ Winafrend Davis 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau Monica Marie Arrington 2202 Herring Creek Drive; Accokeek, Maryland 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. 22, 2004 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 20011 21. Signature of Funeral Service Licenses assanica 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Cardiovascularanes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** urtens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events s a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. he 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2X No раде 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Certification: To 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred funer 1X Natural 5 Pending 24 hours after death. Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martha Bennett, M.D.; 12201 Plum Orchard Drive; Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) State 7 2004 Registrar

			For State Ragistrar	State of Maryla		artment of He tificate of D			ene . No. 2004	42432
	Physicia		1. Decedent's Name (First, Middle, La.	EDTOUR				2. Date of Death Month	Day Year	3. Time of Death
1	/Medic Examin	_	4a. Facility Name (If not institution, give	a street and number)	L (ast birthday)	4b. City, Town, or L	Location of Death  A PAUC  If Under 24 Hrs.	8. Date of Birth	4c. County of Death	MEIZY
	Funeral Director		580-12-6347 Usual Residence of Decedent	Ďм 2□F 80	Yrs.	Months Days	Hours Min.	(Month, Day, Y Sept. 29	, 1924 Tr	inity)
ore, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examination will be multiped at	with the Maryland 3a or 28a-1 show at be notified at	Funeral Director	10a. State 10b. County MD Montgom 10e. Street and Number 9314 Piney Branch	ery Sil	Sity, Town or Lo				). Citizen of What Col	
	ours after deati ral', or Items 2 Examiner uni	by	11. Marital Status 1 ☐ Never Married 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1.6	, etc.
	within 72 ene. then "ne!	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual O (Give kind of work d life. DO NOT use n  Elect				cian	P:	Sb.Kind of Business/Industry	
	d d d	To Be	17. Father's Name (First, Middle, Last, Philip Ventour					Agatha Pa		
	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship ( Joan Ventour/Daug]  20a. Method of Disposition 1 色 Burial 2 □ Cremation 3 □	1ter 20b.	9314 ] Place of Dispo	Piney Bran sition (Name of natory or other place	nch Road	#201 Sil	c. Location - City or	MD 20903 Fown, State
Baitimore,	permit. Pages Department of Important: If it any injury or o		*4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	,) EVE	22		of Facility MCG	uire Fund	rooklyn, N eral Servi ash., D.C.	.ce, Inc.
Physician /Medical Examiner	/Medical	Icai Examiner	23a. Part. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	oquence of):	er the mode of dying,	, such as cardiac o	or respiratory arrest		Approximate Interval Between Onset and Death
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
ecords, P.	The law requires that the tee been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions of	n in Part I.		acco use contribute to the cause of death?  s 2 No 3 Probably 4 Onknown  24b. Were autopsy findings available				
T .		Completed						autopsy performe 1 Yes 2	prior to death?	ompletion of cause of
Division of Vital	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	t 3 DOA Other	. 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how	ce 6 Other (Specinjury occurred	ify)
DIVIS	or Al fter c Direc in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office	office 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or within 24 hours after the Funeral Differential Diff	Medical	29a. Certifier (Check only one)  1 Certifying Pt 2 Medical Example	yslcian: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death nation and/or in	n occurred at the time vestigation, in my opi	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	7 4	>	29b. Signature and fille of certifier			29c. License		29d	12-17-200	Day, Year)
	, )		30 Name and address of person who	y no 76			e mak	omA PA	er mi)	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 22 2	32. Registrar's Sig	nature 4	Sporks		4	-	

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H	Physic /Medi			riss				2. Date of Dea Month	Day	Year 2004	3. Time of Death
	Exami	ner	4a. Facility Name (If not institution, give  University of  5. Social Security Number 6. Se	- maryla	inol e (In yrs. last birthday)	Ba	At More Jif Under 24 Hrs.		4c. County		
	Funeral Director			2 <b>X</b> F 5		Months Days	Hours Min.	8. Date of Birth (Month, Day) 7 / 28 / 19	Year)	Coun	ace (State or Foreigr try) ESSEE
	he Marylan 18e-f show otified at	Director	10a. State 10b. County  Maryland Wicomic	)	10c. City, Town or Lo						Od. Inside City Limits 1X Yes 2 □ No
	ath with t	ral Dire	100. Street and Number 1403 Emerson Ave.			10f. Zip Code 218	01	1	0g. Citizen of V USA	Vhat Count	try?
900	72 hours after death with the Maryland Insturel', or Items 23a or 28e-f show Ocal Examinations be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2💢 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	40	Was Decedent of HII Yes, specify Cub.	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race Blace Specify	e - America k, White, e	an Indian, otc. nite
21215-0036	d within 72 h giene. er then "netu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 11	ucation le completed) College (1-4or 5	+) (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of world	king	Domesti		ustry
Maryland	outd be file Mental Hy arked oth atic event	To Be (	17. Father's Name (First, Middle, Last) Ruba Lee Everhart	Sr.				oe (First, Middle, M Smith	Maiden Sumam	е)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  See 1 show mortonent if them 27 is marked other than "naturel", or flems 23a or 28e-1 show any injury or other treumatic event, it is Medical Examiling uses be notified at Once.		19a. Informant's Name/Relationship (T) Stephanie L. Watso  20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ F  '4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service (Joens	on/daughte	20b. Place of Dispo cemetery, crer Salisbury	Emerson sition (Name of natory or other place r Cremator	ry   12/2	lisbury, Date 2	MD 218	801 City or Tow	vn, State
	/Medical by physician and business the prinal-transit the burial-transit	dical Examiner	28a. Pari - Enter the disease, or composition, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Eart Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a Due to (or as a	the death. Do not entre.  S a consequence of): a consequence of):	er the mode of dyin		or respiratory arre	st,	į	Approximate Interval Between Onset and Death VM (MH)
BOX 6	e attending d for use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery	/ Day Year
, L	aw requiles trat trie as been signed by th 2 should be detache	by	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the un	derlying cause give	en in Part I.	11			cause of death?
r	ate h	Completed						24a. Was an autopsy perform	101	ere autops for to comp eath? Yes 2	y findings available pletion of cause of
DIVISION OF VICAL	this al di	atlon: To Be	25. Was case referred to medical examiner?  Yes 2 No  27. Manner of Death  Natural 5 Pending  Accident investigation	lospital: 1 Inpatier 28a. Date of Injury (Month, Day	28b Time of	28c. Injury Work	er: 4 ☐ Nursing Ho	n (Check only one me 5 ☐ Resider 28d. Describe how	ce 6 □Othe		
SIAID	within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry · At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number State)	r or Rural F	Route Number,
100	within 24 hours at	edical	29a. Certifier 1 ✓ Certifying Phys (Check only one) 2 ☐ Medical Exemit	sician: To the best of ner: On the basis of and manner stat	f my knowledge, death examination and/or inved.	occurred at the tim estigation, in my op	e, date and place, a ninion, death occurr	and due to the cau ed at the time, dat	ise(s) and man e and place, ar	ner as state nd due to th	ed. ne cause(s)
F	3nf	Σ	29b. Signature and title of certifier  30. Name and address of person while co		_	Print)	1643 <u>5</u> R	13038	1. Date signed 2/17 10	(Month, Da	ly, Year)
	Sta Registra	_	Avnher Reiss-140 31. Date filed (Month, Day, Year) DEC 2 2 200	32. Registrar	S. Greene	Sporks	1 timere	MD 2	1201		

			1 - For State Registrar	State of Marylar	•	artment of F			giene 004	42434
	D		1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day Year	3. Time of Death
	Physici: /Medic		James Anthony	Williams, Jr.				Decem	ber 23, 200	9:40 A. M
	Examin		4a. Facility Name (If not institution, giv	e street and number)			r Location of Death		4c. County of Dea	_
			4612 Birchtree L		do no brindhada	Temple If Under 1 Year	Hills If Under 24 Hrs.	O Data of Bio	Prince Ge	
	Funeral Director		5. Social Security Number 6. S 577–40–5752	ex 7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da		rthplace (State or Foreign ountry)
			Usual Residence of Decedent					12/30/	30 120	ila.,Pa.
	rylanc how		10a. State 10b. County	1	ty, Town or Lo					10d. Inside City Limits
	e Ma	cto	Md. P	.G.		Temp	le Hills			ty∑Yes 2 No
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show ta Madical Examinar musi by multified at	Funeral Director	10e. Street and Number 4612 Birchtree I	ano		10f. Zip Code	20748		10g. Citizen of What C	ountry?
	s 23e	eral		12. Was Decedent Ever in U	S 12			acify Vee or No	U.S.A.	erican Indian
	tter de	Fun	11. Marital Status  1 □ Never Married 2X Married	Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
93	al'.o	ρ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: \$52-	53	1 ☐ Yes 2 ☐ No	Specify:		Specify: I	Black
21215-0036	72 ho	Completed	15. Decedent's E	ducation de completed)	(Give	dent's Usual Occup	during most of work	king	16b. Kind of Business	,
21	hen.	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire ce Detect	d)		District of Metropolis	of Columbia
2	filed w Hygiel other ti		12th 17. Father's Name (First, Middle, Last	)	POLIC	e betect		ne (First Middle	Maiden Sumame)	Lair Police
Maryland	a a a	o Be	James A. Will						Williams	
Σ	shoul nd Me mark	2	19a. Informant's Name/Relationship (		19b. Mailin	ng Address (Street			er, City or Town, State,	Zip Code)
Š	nd 2 Lith a 27 Is r tra		June E. Williams/	Wife	4612	Birchtre	e Ln.,Tem	ple Hil	ls,Md. 207	748
ore,	of Head		20a. Method of Disposition  W Burial 2 ☐ Gremation 3 ☐	20b. i	Place of Dispo cemetery, crei	osition (Name of matory or other pla	сө)	Date	20c. Location - City o	r Town, State
Ë	Page ment ent: If ury o		'4 □ Donation   5 □ Other (Special		. Linc	coln Cem.	12/2	8/04	Brentwood	Md.
Baltimore,	permit, Pages Department of H Importent: If Ite any injury or of		21. Signatur Si Funeral Service Lio	nsee	22	2. Name and Addre	ess of Facility ington &	Sons Co	Inc.	
_	₹0 E € Ø		1000	yea (	4	925 Burr	oughs Ave	N.E.	Wash., D.C.	20019 Approximate
ı			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each line.	in. Do not en	ter the mode or dyr	ny, such as cardiac	or respiratory a	rrest,	Interval Between Onset and Death
}	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Metastatic		Cell Car	cinoma			8 Mths.
Н	Examiner			Due to (or as a consec	quence or):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of).					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
Ö,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):					
8760,	icate b physic s the b	dical		d						
9	death certifics e attending ph d for use as tl	/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancv				23d. Date of de	alivon
Вох	atten atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	aldeath 3[	Ectopic pregnanc	у		Month	Day Year
o.		hysl	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown						
٥,	law requires thal lhe as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
Records,	v require been sig should b							10	Yes 2. No 3. F	robably 4 Unknown
ecc	e law requ has been je 2 shoul	ompleted						24a. Was auto	psy prior to	utopsy findings available completion of cause of
<u> </u>	The ate h page	Con						perfo	ormed? death? 2 No 1 Ye	
Vital	icien: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		O#	26. Place of Dea			
of	Physicien: this certific ral director,	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Tîme o	IL 3 DOA			dence 6 Other (Spa how injury occurred	ecify)
o		tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury	₩o	rk? Yes 2 □ No			
Division	Attending r death. sctor: Afte	ifica	3 Suicide 6 Could not to	28e, Place of Injury - At h	nome, farm, st	reet, factory, office		28f. Location (. City or To	Street and Number or F	Rural Route Number,
á	i giệ c	Certification;	4   nomicide	building, etc. (Speci	(Y)			City of You	wii, State)	
	Hospitel			nysician: To the best of my kn miner: On the basis of examin						
		Medical	one)	and manner stated.		29c. Licens			29d. Date signed (Mon	
	To the within To the comple	2	29b. Signature and title of certific	11/.1	1.					
Λ	DIII		20 Normal and a state of the sta		m 230) /Trac		037529		December 27	,2004
2/	5/1Va		30. Name and address of person who				Lane,Laro	FM OT	20774	
	Sta	ate	31. Date filed (Month, Day, Year)				LIDER QUELLE		4V113	
	Regist		DEC 2 8 200	7. Registrar's Sign	And	4				

			1 - For State Registrar	State of Maryl		artment of H rtificate of L			2004	42435
	Physic	ian	1. Decedent's Name (First, Middle, Last Robert	P.		Wummer		2. Date of Death Month December	Day 2004	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give				Location of Death	ecember	4c. County of Death	11:15 A M
	LAGIIII	ııçı	2315 Brinkley Roa			Ft. Wash			Prince Ge	
	. Funeral Director		5. Social Security Number 6. Se 220-44-0547	T44 0 -	vrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth Cou	nplace (State or Foreign untry) ISylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl-f sho	to	Maryland Prince Ge		Ft. Wash					1 ☐ Yes X⊠No
	or 28e	lrec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ıntry?
	23E c	ralD	2315 Brinkley Roa	d		2	20744		USA	
980	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 ie marked other then "natural", or Items 23e or 28e-f show importent: If item 27 ie marked other then "natural", or Items 23e or 28e-f show princy or other treumatic event, Ite Modical Examinar must be notified at ance.	by Funeral Director	11. Marital Status  1 △ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2I\ No	spanic Origin? (Spe n, Mexican, Puerto P Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ucation		dent's Usual Occupa kind of work done d		16	b. Kind of Business/I	ndustry
21215-0036	d within jiene. r then "	Completed	Elementary/Secondary (0-12)	5 College (1-4or 5+)	life.	tholic Pr	-		Religio	ous
Maryland ?	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Raymond A. Wum	mer			18. Mother's Name Hilda K		iden Surname)	
Mary	id 2 shoi ith and N 27 ie ma treuma		19a. Informant's Name/Relationship (T) Rev. Robert Finamo						City or Town, State, Zi n, Marylan	
<u>6</u>	s 1 an f Heal item 2 other		20a. Method of Disposition	20	b. Place of Dispo		.   Di	ate 20	c. Location - City or T	own, State
E	Page: nent o int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify,		ethseman		" 12/30	/2004 La	ureldale,	Penna.
Baltimore,	permil. Departn Importe eny inju		21. Signature of Funeral Service-Livens		6	Name and Address	George P.	Kalas F	uneral Hom 11, Maryla	ne P.A.
			23a. Pa D. Enter the disease, or imposhock, or heart failure. List only o	ne cause on each line.		er the mode of dying	, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Due to (or as a con:						
В	Examiner			Due to (or as a con-	sequence ory.					
	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events	Due to (or as a con:	sequence of):					
•	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
8760,	cate be executed physician and the burial-transit	dical E		d						
9	rificat ng phy as the	0 1	IE ESMALS.	v						
.O. Box	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Day Year
<b>Q</b>	uires that signed by Id be deta	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	n in Part I.		cco use contribute to I	the cause of death?
Records,	The law requir ate has been si page 2 should I	Completed						24a. Was an autopsy performe	d? prior to co	opsy findings available ompletion of cause of
Vital		o o	25. Was case referred to medical				26. Place of Death		Mo 1 ☐ Yes	2 No
of V	ys dir	To B	examiner? 1 ☐ Yes 2 <b>∑X</b> No	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatien	t 3 DOA Othe			e 6 Other (Speci	fy)
ion c	ding After funei	atlon:	27. Manner of Death  1 ★Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work	at 2	Bd. Describe how		
Division	in Dirth	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, office	2	Bf. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	Medical	29a. Certifier (Check only one)  XXCertifying Phy 2 Medicel Exemi	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time restigation, in my op	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
)	To the within To the comple	Σ	29b. Signature and title of certifier	tes Lyen	e MD	29c. License MD	number 12895	29d.	Date signed (Month, 12/27/20	
R	(10)		30. Name and address of person who constantly L. Lu			Print) Street N.	W. #310	Washingt	on, DC 20	0006
	Sta Regist		31. Date filed (Month, Day, Year) DEC 2 8 2004	32. Registrar's Si		2,				

n	<del>1</del> 40		State of Ma State IInpend Item 23a-c&27	aryland / Depa	artment of Hea	Ith and Me	ntal Hygie	711111	42436
	Physicia	an	Decedent's Name (First, Middle, Last)  ALPHONSO DONNEL:			2	. Date of Death Month	Day Year 29, 2004	3. Time of Death 9:47 P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Shady Grove Adventist Hosp:  5. Social Security Number 6. Sex 7. Ag	ital e (In yrs. last birthday)	4b. City, Town, or Local Rockville	ation of Death		4c. County of Death  Montgome:	ry
Z.	Funeral Director	. ,	216-06-6146	20 Yrs.	Months Days Ho	ours Min.	Date of Birth (Month, Day, Ye	1984 N	place (State or Foreign ntry)  [aryland]  10d. Inside City Limits
	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show lical Examinant cust be notified at	rector	MD Montgomery  10e. Street and Number		mantown		10g.	Citizen of What Cou	1 Yes 2 □ No
	death with ms 23a oi	Funeral Director	12919 Pickering Drive		Was Decedent of Hispar f Yes, specify Cuban, M	20874	y Yes or No-	U.S.A.	can Indian,
9800	nours after ural', or ita	þ	A mmed Forces?  1 X Never Married 2 Married  3 Widowed 4 Divorced  A med Forces?  1 Yes, Give Year or Dates:	No 1	1 ☐ Yes 🌠 No Sp	pecify:		Black, White,	etc. Lack
21215-(	I within 72 h ilena. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5  L yr	1+)	dent's Usual Occupation kind of work done during DO NOT use retired) ashier	g most of working		. Kind of Business/Ir	,
yland 2	ould ba filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)  Curtis Davis		18.	Mother's Name (F	irst, Middle, Maid a Warre	,	
e, Mar	1 and 2 she lealth and sm 27 Is m ther traum		19a. Informant's Name/Relationship (Type, Print) Donna Davis (Mother)  20a. Method of Disposition		ng Address (Street and N 9 Pickeri		, Germa		ID 20874
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralla Hygheinal Hygheinal Hygheinal Hygheinal Hygheinal Hygheinal Hygheinal Hygheinal Hism 23a or 28a-f show any injury or other traumatic event, It a Modical Exercitive roust be notified an once.		1	All 1 Sou	natory or other place)  1s Cemete  Name and Address of  46 N. Was	ry 1/4	1/05 G VDEN FU	ermantow NERAL HC	m, MD DME, P.A.
760,	/sicia	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ARRAYTHMIA a consequence of): ARKINSON—WI a consequence of):		ME			Approximate Interval Between Onset and Death
P.O. Box (	w requires that the death cardifica bean signed by the attending ph should be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
ords, P	equires that an signed to ould be deta		Part II. Other significant conditions contributing to death b	ut not resulting in the un	nderlying cause given in	Part I.		co use contribute to to	he cause of death?
al Reco	ician: The law ru certificata has be rector, page 2 sh	Completed					24a. Was an autopsy performed 1 🏿 Yes 2 🗆	? prior to co	ppsy findings available impletion of cause of
Division of Vital Records,	phys this al dii	ation: To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  1 Inpatie  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Inju (Month, Date)		t 3□ DOA Other: 4	280		6 Other (Specification)	<b>(y</b> )
Divis	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injuiding, etc.	ury - At home, farm, stre c. (Specity)	eet, factory, office	28f	. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	estigation, in my opinior	n, death occurred	at the time, date a	and place, and due to	o the cause(s)
	To To	Σ	29b. Signature and title of certifier			.M.E.		Date signed (Month, cember 30,	
			30. Name and address of person who completed cause of d	111	Penn Street	t, Baltin	nore, Man	cyland 212	201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registro	ar's Signature	uli				

				1 - For Stete Registrar	State of M	Maryla		artment (		d Mental Hy	3	(
		Physic /Medi	cal	Decedent's Name (First, Middle,     SHARON ERA WAR     Secility Name (If not institution)	D					2. Date of Dea	20 2004	2 Tiple of Death 7
		Exami	ner		vai medica	2/ 6	MWW last birthday)	4b. City, To	wn, or Location of D SAUSBURY Year   If Under 24		46. County of Dea	MICO
1		Funeral Director		219-46-4951 Usual Residence of Decedent	1□ M 2\ F	58	Yrs.			Hrs. 8. Date of Birt Min. (Month, Day MARCH I	6,1946 MAR	thplace (State or Foreign ountry) YLAND
195	1	Maryland I-f show	tor	10a. State 10b. County DELAWARE SUSSEX		10c. C	ity, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2X No
7-1	Z	fler deeth with the Maryla r Hems 23a or 28a-f shor ill ar must be notified at	<b>Funeral Director</b>	10e. Street and Number	DOAD			10f. Zip Co			10g. Citizen of What C	ountry?
7,0	KY.	eeth ns 23	eral	36028 ST. GEORGE	ROAD  12. Was Deceder	nt Ever in I	10 12 1		940	) (0# NN	USA	
316	5-0036	within 72 hours after deeth ene. than "natural", or items 23 the Madical Execution rusi	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	<u>ş</u> ? ∭iNo	1	was Deceden f Yes, specify		? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi	te, etc.
MARIN	1215-	within 72 h ane. than "natt	Completed	15. Decedent's (Specify only highest (Secondary (0-12) 1 2	Education grade completed) College (1-4o	r 5+)	16a. Deced (Give life. L		occupation done during most of retired)	working	16b. Kind of Business BEAUTY SHO	,
Shi	Maryland 2	be filed ntal Hygi nd othar evant, II	To Be Co	17. Father's Name (First, Middle, La DORSEY JOHN ERA	st)		DEAUT	IOIAN		Name (First, Middle, LEE BRADSH	Maiden Sumame)	0.5
Ward	e, Mary	ges 1 and 2 should t of Health and Mer If item 27 Is marks or othar traumatic		19a. Informant's Name/Relationship GORDON W. WARD/H			36028	ST. G	EORGE ROA	D, DELMAR,	r, City or Town, State, DE 19940	Zip Code)
R	Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spe		e '	Place of Dispo cemetery, cren EMATORY	natory or othe	of r place) LMARVA 12/	Date 22/2004	20c. Location - City or DELMAR, DE	
	Balt	permit. Departr Importa		21. Signiture of Funeral Service (	J. Sell	en	Z. 1	ELLER 1	ddress of Facility FUNERAL HO N STREET,	OME, P. O. EAST NEW	BOX 207 MARKET, MD	
		Pnysician /Medical		Asa. Pan 1. Enter the disease, or construct, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a \$.	taph	bcocc		dying, such as card	liac or respiratory arr	est,	Approximate therval Between Onset and Death
		Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	mulf	Toke	my	eloma			
	8760,	ate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	s a conseq	quence of):					
	89	tificate ig phy as the	edic		d							
	.O. Box 6	Attending Physician: The law requires that the death certific rideath, rideath, rideath ar death secrificate has been signed by the attending p actor. After this certificate has been signed by the funeral director, page 2 should be detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom  1 Live birth  4 Pregnant  9 Unknown	2 Feta	al death 3 🗌	Ectopic pregn Other (specif			23d. Date of del Month	ivery Day Year
	Division of Vital Records, P.O.	w requires that s been signed b should be deta		Part II. Other significant conditions	contributing to death	but not res	sulting in the un	derlying cause	e given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
	Reco	he law rec has bee ge 2 shot	Completed							24a. Was a autops perform	v prior to d	topsy findings available completion of cause of
	tal	ysician: The lar is certificate has director, page 2		25. Was case referred to medical					00 Pt	1 ☐ Yes 2	2 □NO 1 □ Yes	2 □ No
	<u> </u>	Physicia this cert al direct	To Be	examiner? 1 \( \text{Yes} \) 2 \( \text{NO} \)	Hospital:	ient 2□	ER/Outpatient	3□ DOA	Ottore	Home 5 Reside	e) ince 6 □Other <i>(Spe</i> d	
	0 0	ding Ph n. After th funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inj (Month, D		28b. Time of		Injury at Work?		w injury occurred	ary)
	Sio	vttendii death. ctor: A / the fu	catio	2 Accident investigate 3 Suicide 6 Could not	on			М	1 ☐ Yes 2 ☐ No			
	5	i i ite	Certification:	4 Homicide determine	d 28e. Place of Ir building, e	etc. (Specir	y) 			City or Town		·
		To the Hospital within 24 hours a To the Funeral C completely filled i	edicai	29a. Certifier Certifying F (Check only one) 2 ☐ Medical Exa	Physician: To the bes iminer: On the basis and manner s	or examina	wledge, death tion and/or inv	occurred at the stigation, in r	e time, date and pla ny opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
•	)	To t To t	X	29b. Signature and inte of certifier					oense number	_	od. Date signed (Month)	, Day, Year)
				30. Name and address of person who	completed cause of	death (Item	n 23a) (Type, P	-	E CARROL	1 ST. SAL	spung, m	1021801
				31. Date filed (Month Pay) 9	2004 32 F ist	trar's Signa	1 Cn	nsula	Regiona	1 Medic	al (enter	
	9.	Sta Registra		DEU 23	2004	July 1	JE A	3346	118			

			1 - For State of Maryland / Depa	rtment of Health and Me tificate of Death		ene	42438
ı	Dhyeisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medio		IOND INCOCCED WINTONE SW		ĎĔC	24 2004	12:05AM
	Examir	ner		4b. City, Town, or Location of Death		4c. County of Death	1
H	<u> </u>		CIVISTA MEDICAL CENTER  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	LAPLATA  If Under 1 Year   If Under 24 Hrs.	9 Date of Birth	CHAR	
	Funeral Director		213-22-4927 1XM 2 F 73 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, June 27,	Year) Cou	place (State or Foreign Intry) Yland
	ъ		Usual Residence of Decedent		rune 27	1931   Mai	yranu
	death with the Maryland ms 23a or 28a-f show real be notified at	_	10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	he M	Director	Maryland Charles Waldorf				1 ☐ Yes 2X No
	a or 2	Ö	10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	,
	Jeath	Funerai	1117 Clark Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	20602 as Decedent of Hispanic Origin? (Spec		Inited Stat	<del></del>
٥	after o	臣	Armed Forces?  1 □ Never Married 2 M Married 1 M Yes 2 □ No If Yes, Give 1	Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Black, White	
2	ral', o	by	3 Wildowed 4 Divorced Year or Dates:	☐ Yes 2Ã No Specify:		Specify:	nite
12-0036	within 72 hours after ene. than "natural", or Ite ne Medical Exemina	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k.	ent's Usual Occupation ind of work done during most of working	a 1	6b. Kind of Business/I	
V	within ne.	I di	Elementary/Secondary (0-12) College (1-4or 5+)	ONOT use retired) cam Analyst		JS Governme	n+
N	filed v Hygie other t			18. Mother's Name (	-		enc
yland	d be i	o Be				alderi Surname)	
	should be fand Mental Its marked of	2		Mary Tillm Address (Street and Number or Rural)		City or Town, State, Zi	Code)
Z	and 2 eatth a n 27 Is			Clark Ave., Waldor			3020)
ē,	- I 5 =		20a. Method of Disposition 20b. Place of Disposi	ition (Name of atory or other place)		0c. Location - City or T	own, State
aitimor	Pages nent of int: If it iry or o		Burial 2 Cremation 3 Hemoval from State	ns' Cemetery 1-3-2	2005	Cheltenha	m MD
<u>=</u>	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee MO1 04 C 22.	Name and Address of Facility			
מ	825 29		lack the will you	Huntt Funeral Home	orf. MD	20604-015	6
			shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac of	respiratory arres	st,	Interval Between
	Physician		Immediate Cause (Final disease or condition	EXECTINAME of	FAU	ET.	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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Š	w requires that the death certifit been signed by the attending f should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy		23d. Date of deliv	ery
, n	e dea he att	sici	in the past 12 months?  1   Yes 2   No 4   Pregnant at time of death 5   0	Other (specify)		Month	Day Year
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'n	ires the signed at the control of th	l by	Part II. Other significant conditions contributing to death but not resulting in the und	errying cause given in Part I.		cco use contribute to t	
spiosa	requ	etec			-		
ב	e law has t	Completed	•		24a. Was an autopsy performe	prior to co	ppsy findings available mpletion of cause of
0	ician: The lav certificate has rector, page 2				1 ☐ Yes 2	No 1 ☐ Yes	2 No
VII.	sicial certi	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient	26. Place of Death (			
5	g Phys er this eral di	<b> -</b>	27. Manner of Death 28a. Date of Injury 28b. Time of	To real straining Home	d. Describe how	ce 6 Other (Special	y)
VISIOUS	Attending I death. ctor: After y the funer	atio	1X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
2	er dez ectol	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	at, factory, office 28	f. Location (Stre City or Town,	et and Number or Rura	al Route Number,
5	rs after al Director	Certification:	building, etc. (Specify)		City of 10wil,	State)	
	dospi t hour uner	edicai	29a. Certifier (Check only (Ch	occurred at the time, date and place, and	d due to the cau	se(s) and manner as s	tated.
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medi	and manner stated.				
	To To	~	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	Day rear)
			Jeon one	D-20629		10/2	1104
h	P541		30. Name and accordings of person (Mo completed cause of death (Item 23a) (Type, Pr				,
[7]	Sta	te	31. Date filed (Month, Day, Year) 32. Recettar's Signature	OKE SQ. STE 103	3 WALDO	ORF,MD 20	603
	Registr		DEC 2 7 2004 Shows &	barles			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last)
Juanita M. 2. Date of Death Dech. 23, Day **Physician** White 200<sup>Y</sup>4<sup>ar</sup> /Medical <sup>4a.</sup> Facility Name *(If not institution, give street and number)* Washington Adventist Hospital 4b. City, Town, or Location of Death Takoma Park **Examiner** 4c. County of Death Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March 1 Pay 1 Year) 37 7. Age (In yrs. last birthday) 5. Social Security Number 5 79 – 4 6 – 2 2 3 4 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Director Wash. Usual Residence of Decedent 10b. County ir than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 10c\_City, Town or Location Washington D State 10d. Inside City Limits Director 1 XYes 2 No 4410-15th St. N.W. 10g. Citizen of What Country? 12.7ip Cod Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after d il Hygiene. other than "natural", or Itam Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3X Widowed 4 □ Divorced SpecifBlack Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry bo Not use retired) Aid Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If tiem 27 is marked other that any injury or other traumatic event. It and once. 12 17. Father's Name (First, Middle, Last)
George E. Mitchell 18. Mother's Name (First, Middle, Maiden Surname)
Bessie A. Jackson Be 19a. Informant's Name/Relationship (Type, Print) Robert C. White - Son 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 4705 Hamilton St. Hyattsville, Md 20781 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Fort Lincoln CemetDec30,04 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Md \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur) of Fymeral Service Lice Robinson Funeral Home 1313 6th St. Washington, D.C. 20001 23a. Part / Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nerymenta offic physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Be Completed by Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Month 4 Pregnant at time of death Year 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Yes page 2 should 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 Yes 1 Tes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28c. 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 24 hours after death.

Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 24 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) eanne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deanna White, MD 7600 Cornell White, MD Carroll Ave. Takoma Park Md. 20912 7600 31. Date filed (Month, Day, Year, Registrar's Signature State Registra

			1 - For State Registrar	State of	Maryland /		artment rtificate			and M		gienen Reg. No.	104	L	2440
	Dhusisi		1. Decedent's Name (First, Middle, Last,								2. Date of Dea Month		Ye		3. Time of Death
	Physici /Medio		Barbara J. Amtow	er							Decembe	er 26	, 200	04	5:55 a M
	Examir	er	4a. Facility Name (If not institution, give						Location o				County of D		
			Wilson Healthcare  5. Social Security Number 6. Sec		oury Villa		If Under		rsbur    Under:		0. David V B: 41		Montg		
	Funeral Director			M 21€F	80	Yrs.	Months	Days	Hours		8. Date of Birth (Month, Day Sept. 1	Year)	9. 924 !	Count	ace (State or Foreign lry) Land
	ס		Usual Residence of Decedent									_,			
	arylar	Ļ	10a. State 10b. County		10c. City, To									10	d. Inside City Limits
	8a-f	Director	Maryland How	ard		High									1 ☐ Yes 2 🔼 No
	a or 2		10e. Street and Number				10f. Zip				1	10g. Citize	en of What		ry?
	eath	erai	13491 Allnutt La:	ne 12. Was Decede	ent Ever in U.S.	13 \		0777	nanic Orio	nin2 /Sno	oify Voc or No.	14	USA 4. Race - A		no lodino
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinant must be notified at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ŒNo		Yes, spec		Specify:	, Puerto F	cify Yes or No- Rican, etc.)		Black, W	/hite, e	itc.
21215-0036	2 hou	ted	15. Decedent's Edu	cation		a. Deced	lent's Usua	1 Occupat	tion				d of Busine		
2	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	life. l	kind of won OO NOT us	k done di e retired)	uring most	of workin	g				
7	ygien ygien t.	Con		4		Home	emake						wn Ho	ome	
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)	- h							(First, Middle,	Maiden S	umame)		
$\frac{3}{2}$	houid d Mer marke matic	ို	Thomas Kingsnor  19a. Informant's Name/Relationship (Ty			21 14 11		/0:			undle				
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ē,	Heal tem		Mark Amtower/ Son 20a. Method of Disposition	1	20b. Place	of Dispo	sition (Nam	e of	1 _		ghland, ber 27				vn, State
e E	Pages ent of nt: if i		1 ☐ Burial 2 【XCremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	Metrop		atory or oti		)	20					/irqinia
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	200	Qo.	£2	rancii	Address	ceil eitv	ins :	Funeral	Hom	e Inc		, MD 2090]
			23a. Part1. Enter the disease, or comp	cations that caus	sed the death. De									-	Approximate
4	Pnysician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Leu	a a consequence	-	d	em	enti	٩					Interval Between Onset and Death
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Dun to (or	as a consequenc	4\									
8760,	be exician ician burial			10) Of BDC	as a consequenc	e 01):									
587	phys s the	edicai									<del></del>			+	
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcor								23	d. Date of	deliven	v
o. M	The law requires that the death certifi te has been signed by the attending bage 2 should be detached for use as	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		2 □ Fetal dea t at time of death n		Ectopic pre Other (spe						Month		oay Year
0	s that ned b e deta	by Ph	Part II. Other significant conditions con	tributing to death	h but not resulting	in the un	derlying ca	use giver	in Part I.		23e. Did tob	acco use	s contribute	to the	cause of death?
rds	w requires been sign should be										1 □ Y€	s 2	No 3 🗆	Probal	bly 4 🗀 Unknown
Records,	awre	Completed									24a. Was a		24b. Were	autops	sy findings available
		Com									autops perform	y ned? □ No	death	to com ? 'es 2	pletion of cause of
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	Check only on	,			
ot	Physic this co	2	1 □ Yes 2 □ No	ospital: 1 🗌 Inpa		-		-	4 Nur	sing Hom	e 5 🗆 Reside	nce 6[	□Other (S	pecify)	
UC C	ding P h. After funera	lon	27. Manner of Death 1 → Natural 5 → Pending	28a. Date of It	njury Day Year) 28b.	Time of Injury		c. Injury a			ld. Describe ho	w injury o	occurred		
Division	I or Attendi after death. Director: A in by the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of	Injury - At home,	farm stre	M et factory		es 2□N		f. Location (St	met and l	Numberor	Dural	Pauta Numbar
2	at or At after t Direc d in by	Certification:	4 ☐ Homicide determined	building,	etc. (Specify)	tami, stie	ot, ractory,	Office		20	City or Town	, State)	VUITIDBI OI	nurari	noute Number,
	To the Hospital or Attending Physician: whithin 24 hours after death as a feet the form of the Funeral Director: After this certifical completely filled in by the funeral director.	edical C	29a. Certifier 1 Cartifying Physical Check only one) 2 Medical Examination	ician: To the be ler: On the basis and manner	of examination a	ge, death and/or inv	occurred a estigation, i	t the time	, date and nion, death	place, an	nd due to the ca	use(s) ar ate and pl	nd manner lace, and d	as stat	red. he cause(s)
	To the within 2 To the complet	Me	29b. Signal are and title of certifier					License i		***************************************		9d. Date s	signed (Mo	nth, Da	ay, Year)
	2		of R. Mr	luch.	MD			D19	7291	1		Deco	: man	20	,2004
			30. Name and address of person who co	mpleted cause o	f death (Item 23a	) (Туре, Г	Print)		/	/		1	2 0	<b>a</b> ^	, 2004
			John R. Meln		11 Pull	ell A	Jul ,	69	the	nola	y Me		201	17	
	Sta Registra		31. Date filed (Month, Day, Year) DEC 2 7 2004	32 Hegi	strar's Signature	9	Span	KS	9291 1. + he		• •				

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Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)      William      4a. Facility Name (If not institution, give stre	Reeves		Llen City, Town, or	Jr Location of	2. Date of Month  Decen	ber :	ay Year  21. 2004 c. County of Deatl	3. Time of Death 9:45 a
Funeral		Montgomery General  5. Social Security Number  6. Sex	7. Age (In yrs. last birtl	Mo	Olnor 1 Year	ey If Under 24 Hours	Hrs. 8. Date of (Month,	Birth Day, Year	Montgom	Pry nplace (State or Fore untry)
Director		183 09 4870 Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	rs.	n .					sylvania  10d. Inside City Lim
the Mary	Director	Maryland Montgome 1  10e. Street and Number	y Wheaton		f. Zip Code			10g. C	itizen of What Co	1 🗆 Yes 2 <b>X</b>
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or itams 23e or 28e-f show event, if a M.dicel Ext. all the ficilitied at	Completed by Funeral D	12521 Kuh1 Road  11. Marital Status  1 Never Married 2 Married  XXWidowed 4 Divorced  15. Decedent's Educat (Specify only highest grade company)  Elementary/Secondary (0-12)	ompleted)	If Yes  1  Y  Decedent's (Give kind)	2090: Decedent of His, specify Cuban es XXNo  Usual Occupator work done do OT use retired)	spanic Origin Mexican, I Specify: tion uring most of	n? (Specify Yes or Puerto Rican, etc.) of working	No-	14. Race - Amer Black, White Specify: <b>B1</b> &	rican Indian, ,, etc. 1 <b>ck</b>
should be filed withir ind Mental Hygiene. s merkad other than umatic evant, ILe M.	To Be Con	12 17. Father's Name (First, Middle, Last) William Reeves Alle		Carp	enter		Spain		nber Comp	any
. a a =		19a. Informant's Name/Relationship (Type) Nancy A. Nelson / I	Print) 19b.			nd Number	or Rural Route Nu	-334		ip Code)
Pages 1 and 2 ent of Health ant: if item 27 inty oc other tree		20a. Method of Disposition 1 □ Burial 3 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify).	oval from State 20b. Place of i	Disposition , cremator	(Name of or other place	)	Date 2/28/2004	20c. L	ocation - City or 1	
permit. Pages 1 Department of F important: if ite any injury or ot once.		21. Signature of Funer (S rvio Licensee	(du.	22. Nan	ne and Address	of Facility	lines Rin	aldi	Funeral	
Fnysician /Medical Examiner		23a Part1. Enter the disease, or complicat shock, o heart failure. List only one dimmediate Cause (Final disease or condition resulting in death)	ions that caused the death. Do no ause on each line.  NYOW  Due to (or as a onsequence of	ot enter the	mode of dying,	, such as ca	rdiac or respirator	y arrest,	er opring	Approximate Interval Between Onset and Death
cate be executed physicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of							
death certifi e attending I d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		oic pregnancy or (specify)				23d. Date of deliving Month	ery Day Year
signed d be de	by	Part II. Other significant conditions contrib	outing to death but not resulting in	the underly	ing cause giver	n in Part I.			. /	the cause of death?
	Completed			-			24a. W au pe 1 🗆 Yes	topsy normed?	prior to co	opsy findings availab impletion of cause of
ing Phya ifter this uneral dir	ation; To Be	1 105 211110	oital: 1		DOA Other 28c. Injury a Work?	4 🗋 Nursi	Death (Check onling Home 5 \sum Re 28d. Describ	sidence		(y)
	Certification;	a Could not be	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, fa	ctory, office		28f. Location City or 1	(Street ar Town, State	nd Number or Rur. e)	al Route Number,
To the Hoepital or within 24 hours after to the Funeral Discompletely filled in	edicai	one)	en: To the best of my knowledge, On the basis of examination and/ and manner stated.	death occu /or investig:	rred at the time ation, in my opir	, date and p nion, death	place, and due to the occurred at the time	ne cause(s e, date and	) and manner as s d place, and due t	stated. o the cause(s)
of Milk Food	M	29b. Signature and title of certifier	M.O.		29c. License i				ute signed (Month,	
			10, 18111 PVI	「ype, Print) ✓( ८	Phillip	DV1	ve Suite	304	Olney	, 2004 Maryland
Sta Registr		31. Date filed ( <i>Month, Day, Year</i> ) <b>DEC 2 7</b> 2004	32. Registrar's Signature	1	oaks					

			1 - For State Registrar		aryland / De <sub>l</sub>	partment of F ertificate of	Health and Death		gie <b>z</b> e	) 4	42442
	Physic /Medi		Decedent's Name (First, Middle, L.	JEAN	AUS	STIN		2. Date of Dea Month DEC . 2	Day 22, 20	Year O 4	3. Time of Death  11:12 P <sup>M</sup>
).	Exami		4a. Facility Name (If not institution, gi CARROLL HOSPI			4b. City, Town, o	or Location of Deat		4c. Count	y of Death	
	Funeral Director		5. Social Security Number 6. 142-30-4067		e (In yrs. last birthda 66 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	h y, Year)	9. Birth	place (State or Foreign
	faryland show	'n	Usual Residence of Decedent  10a. State  10b. County	т т	10c. City, Town or						10d. Inside City Limits
	th with the N 23a or 28e-f	Funeral Director	MD. CARRO  10e. Street and Number  1045 HOOK RD.	T1 T1	WESTMIN	10f. Zip Code	21157		10g. Citizen of	What Cour	1 □ Yes 2 No
920	72 hours after death with the Maryland netural", or items 23a or 28e-f show after Examiner is wat be recitled at	by	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2011 If Yes, Give Year or Dates:		I. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		pecify Yes or No- o Rican, etc.)		ce - Americ ck, White, fy: WHI	etc.
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5	(Giv	edent's Usual Occup re kind of work done DO NOT use retired EHOUSE C	during most of word)	E .	16b. Kind of B		
land 2	ould be filed Mental Hygid tarked other tetic event, II	To Be Co	17. Father's Name (First, Middle, Last THOMA		NDLEBURY		18. Mother's Nam	ne (First, Middle, I		ne)	
	nd 2 sh Ith and 27 is rr r treum		19a. Informant's Name/Relationship GEORGE E. AUST	,		ling Address (Street 5 HOOK R					
Baltimore,	Pages 1 arenent of Heanur; if item		20a. Method of Disposition  1 Burial 2X Cremation 3 ()  4 Donation 5 Other (Speci		20b. Place of Disc	position (Name of ematory or other plac	<sup>(2)</sup> 12/:	Date 30/04	20c. Location	City or To	
Balt	permit. Pages Department of Importent: If if eny injury or once.		21 Signature of Funerary Service Lice		2	22. Name and Address	AIN ST.	,WESTMI	NSTER,		OME 21157
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a		nter the mode of dyin			est,		Approximate Interval Between Opset and Death
68760,	tificate be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
.O. Box	The law requires that the death certific ten law requires that been signed by the attending page 2 should be detached for use as a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 l	□Ectopic pregnancy □ Other (specify)			23d. Dat	te of deliver	ry Day Year
rds, P.	es be	by	Part II. Other significant conditions of	contributing to death bu	t not resulting in the t	underlying cause give	en in Part I.		_	ibute to the	e cause of death?
al Records,		Completed						24a. Was ar autopsy perform 1 Yes 2	y p	rior to com leath?	sy findings available apletion of cause of
Division of Vital	tending Phy leath. tor: After this the funeral d	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be		Year) 28b. Time o	of 28c. Injury Work M 1 \square	er: 4 □ Nursing Ho at er: er: er: er: er: er: er: er: er: er:	h (Check only one ome 5  Resider 28d. Describe ho	nce 6 Othe	ed	
DIV	Dir		4 Homicide determined  29a. Certifier 1 Certifying Ph	building, etc.	f my knowledge, deat	h occurred at the time	e date and place	28f. Location (Str. City or Town,	, State)		A. d
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in I	Medicai	(Check only one)  2 Medical Example of Certifier	niner: On the basis of and manner stat	skannnauon anu/or m	vestigation, in my op	inion, death occurr	red at the time, da	use(s) and mar ite and place, a od. Date signed	ind due to t	the cause(s)
)	WIL		30. Name and address of person who	completed cause of a	ath (Item 23a) (Type	D 00	4431	62	Decem	Ser	23,2004
	Sta		ENRICOAGIP 31. Date filed (Month, Day, Year)	NGERWS 32. Registrer	O M.D.	200 MEM	IORIAL AL	LENKE	WE	STMIA	USTER MD
	Registra	_	UEC 2.7	7 7004 1	S 7.	934					41101

State of Maryland / Department of Health and Mental Hygiene 42443 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year Physician MINNIE 4:30 AM AMBERS December 24, 2004 4c. County of Death /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4513 22nd Avenue Prince Georges Mt. Rainier If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) May 06, 1904 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1□ M 2XF 100 Yrs 231-56-1230 Lucketts, VA Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Heelih and Mentel Hygiene.
Important: If item 27 Ia marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits MD. Mt. Rainier Princes Georges X□Yes 2□No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4513 22nd Ave. 20712 Funeral 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black þ 3 Widowed 4 Divorced Yeer or Dates Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 6th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Hillary Susan Virginia Bel1 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 4513 22nd Ave Mt. Rainier, MD. 20712 Jarma J. Thompson, Niece 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/31/04 | Lucketts, VA. Mt. Pleasant Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Bianchi F.S. 814 Upshur St. NW, Washington, DC. 20011 23a. Pert1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Pneumonia 3 weeks Examiner Due to (or es a consequence of): Examine Aspiration of Gastric Contents 3 weeks physician and s the buriel-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of)  $\mathcal{H}: \quad \mathcal{JH}(a,b)$  of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending phase at the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the a should be deteched 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes XXX No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure þ Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed efter death. I Director: After this certificete hes b d in by the funerel director, pege 2 s 1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer' Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🂢 Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 X No 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Atterwithin 24 hours efter de:
To the Funeral Director
completely filled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of bertifier 29c. License number 13026 12/28/2004 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Stephen M. Seabron, MD, PC 1140 Varnum St. NE Ste#209 Wash. DC. 20017

State Registrar 31. Date filed (Month, Day, Year)

DEC 2 9 2004



DHMH 16 Rev 6/95

			State of Maryland / Dep	partment of Health and Me ertificate of Death	ental Hygier Reg. 1	
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Day Year 3. Time of Death
	/Medic Examin	al	Philip Wayne Burnett, Sr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	December =	Jay Jeary 8.32 AM  4c. County of Death
*	Examin	CI		Hagerstown	W	ashington County
	Funeral		Washington County Hospital  5. Social Security Number  6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		216-54-8668 11 FM 2017 53 Yrs. Usual Residence of Decedent	<b></b> *	eb 4 19	51 Maryland
	iryland show	_	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits 1 Xes 2 ☐ No
	he Ma 28a-1 s	Director	Maryland Washington Hage	rstown 10f. Zip Code	100	Citizen of What Country?
	a or 3		650 Westwood Street	21740	109.1	U.S.A.
	ms 2	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
Maryland 21215-0036	hours after death with the Maryland tural', or Items 23a or 28a-1 show al Examinar must be nutilised al	by	1 Never Married 2 Married 1 No If Yes 2 No If Yes 2 No If Yes Give Year or Dates:	1 ☐ Yes 🏖 No Specify:	noari, etc.)	Black, White, etc.  Specify: Black
2-0	72 na	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of workin	g 16b.	Kind of Business/Industry
121	within tene. than "	duic	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)  Maintenance		Dublic Housing
d 2	Hyg the the	a)	12 17. Father's Name (First, Middle, Last)	18. Mother's Name		Public Housing  for Sumame)
/lar	o d a b	To B	George A. Burnett	Gertrud	e Burns	
Jan	0 0 00			iling Address (Street and Number or Rural		
	1 an Heal em 2 ther		20a Method of Disposition 20b. Place of Dis			Location - City or Town, State
nor	of t		1 Rurial 2 Cremation 3 Removal from State	in the place 1 12–30 in the place 1 12–30	1.	gerstown Maryland
Baltimore,	permit. Pag Department Important: I any injury o			22. Name and Address of Facility Dou	glas A. F	
		1	23a. Part 1. Enter the disease, or complications that caused the d-ath. Do not e shock, or heaft failure. List only one caused on each time.			Approximate Interval Between
	Enysician		Immediate Cause (Final disease or condition	deal subjection	N	Onset and Death
	/Medical Examiner		resulting in death)  aue to (or as a cons. quence of):	111A-		- Sa. a
	Lxammer	<u></u>	Sequentially list conditions, if any, leading to minimulate b. Lue to (or as a consequence of):	elles .		Plais
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c			
ó	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	ate hy: the	Physician/Medical	d			
9	eath certific attending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death e atter d for u	iciar	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death	B □Ectopic pregnancy i □ Other (specify)		Month Day Year
P.0	at the de by the a stached	hys	9 ☐ Unknown			
ທົ	The law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	by	Part II. Dther of gnificant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?  2 Probably 4 Unknown
Record	e law re has bei je 2 sho	Completed	Mype-1/2 Denus		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>=</u>	Ø <u>□</u>				performed?	
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to examiner?  1 ☐ Yes 2 ☐ No. Hospital: 1 ☐ Inpatient 2 ☐ EN/Outpat	ent 3 DOA Other: 4 Nursing Hom		6 ☐Other (Specify)
of	g Phya er this ieral di	-	27. Manner Leath 28a. Date of Injury 28b. Time	of 28c. Injury at 2	8d. Describe how in	
sior	Attending F r death. ector: After by the funer	atio	2 Accident investigation	M 1 Yes 2 No		
Division	spital or Attencours after deathous after deatheral Director: filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 2	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	Hos 4 h Fur ely	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de composition and/or and manner stated.			
)	To the within 2 To the complet	Me	29b. Signature and title of certifier  SAMUEL CHAN, MO	29c. License number  1) 36655	Dec.	Date signed (Month, Day, Year) 2 - 27; ZUCY
6	114+1		30. Name and address of person who completed cause of death (Item 23a) (Typ. 324 EUS) HW / I (I HM S/NUT / JU)	Pe 200. HAGENS	town,	MD 31740
	Sta Registi		31. Date filed (Month Day, Year) 2004 32. Registrar's Signature	perke		

State of Maryland / Department of Health and Mental Hygiene 001, 42445

			Certificate of Death	Reg. No.
		1. Decedent's Name (First, Middle, Lest)		2. Dete of Deeth Month Day Year  3. Time of Death
-	Physiciai /Medica	Errord - V Dlasthon		December 24, 2004 1130 AM
	Examine	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or Lo	ocation of Deeth 4c. County of Death
		Heartland Health Care Center		
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest	Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer)  9. Birthplece (Stete or Foreign Country)
	Director	249-24-1861		Aug. 8, 1916   South Carolina
	pue *	Usuel Residence of Decedent  10e. State 10b. County 10c. City, T.	own or Location	10d. Inside City Limits
	ah o			1 □XYes 2 □ No
	288-1	Maryland Prince George's	Adelphi 10f. Zip Code	10g. Citizen of Whet Country?
	ti o d	100. Street end Number		
	iffer death with the Mei r items 23s or 28s-f s riner must be notified	1801 Metzerott Rd.  11. Merital Status 12. Was Decedent Ever in U.S.	20783	United States ecify Yes or No- 14. Race - American Indian,
_	ter d	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuben, Mexican, Puerto	Rican, etc.) Black, White, etc.
20	irs at	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐XNo Specify:	Specify: Black
Maryland 21215-0020	2 hot	15. Decedent's Education	6e. Decedent's Usual Occupation	16b. Kind of Business/Industry
7	led within 72 hor lygiene. Ner than "natura nt, the Modical E	(Specify only highest grede completed)  Elementery/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing
7	d wit	10th	Factory Worker	Private
פ	tal Hyge file d other	17. Father's Neme (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)
<u>a</u>	Ments Ments arked artic	Walter William		Dessie Felder
ar	sho and N		9b. Mailing Address (Street and Number or Run	el Route Number, City or Town, State, Zip Code)
Σ	and 2 alth a 27 is	Louise Thomas - Daughter	8816 Saunders Lane,	Lanham, MD 20706
Se	ten the series	Come	of Disposition (Name of etery, cremetory or other plece)	Date 20c. Location - City or Town, State
Ĕ	Pege int: If	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	orbett Cemetery	12/30/04 Bishorville, SC
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Menyland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at page.	21. Signature of Funeral Service Licensee		tewart Funeral Home
œ ·	S OF P	De Tonor July	4001 Benning Rd.	., N.E. Wash., DC 20019
	Name of Street	23a. Pert 1. Enter the diseese, or complications that cause. The death. D	o not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate
4	Physician	shook, of heart failure. List only one cause on eech line.		Interval Between Onset end Death
1	/Medical	Immediate Cause (Final disease or condition	LENOTECLANDIONA	10 CAR DISPARENTE
1	Examiner	resulting in death)  Due to (or as	a consequence of):	Back Disease parto
	7 - 5			1
	The law requires that the death certificate be executed that hes been signed by the attending physician and page 2 should be detached for use as the bunal-transit commissed by Dhysician Mandles Exemines.	Sequentially list conditions, Due to (or as	a consequence of):	
oʻ	e e e e e e e e e e e e e e e e e e e	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury		1
68760,	ate b hysic the b	that initiated events resulting in death) Last Due to (or as	e consequence of):	
9 ×	antific ing p			
Bô	that the death ce led by the attendi detached for use	d		
-	at the death or d by the attend leteched for us	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
P.0	d by t	Cerebral infarction		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
Ś	w requires that been signed t should be det	Ce. still are por	<u> </u>	
2	een s	None entities		24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause
Records,	hes by	St. Williams		of death?
	The law requires the state has been signed page 2 should be d			1 Ves 2 No 1 Yes 2 No
Vital	Physician: r this certific tral director,	25. Was case referred to medical examiner?		h (Check only one)
5	hysic his ce ti dire	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/		me 5 Residence 6 Other (Specify)
ב	fler than	27. Mennes of Death 28a. Dete of Injury 28b. 1 ☑ Natural 5 ☑ Pending (Month, Day Year)	Injury Work?	28d. Describe how injury occurred
S	Attending or death. ector: After by the funa	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	
Division	tal or Attending P rs after death. al Director: After t led in by the funare	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office	<ol> <li>Location (Street and Number or Rurel Route Number, City or Town, State)</li> </ol>
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completaly filled in by the funaral director, page Madical Cartification: To Re Com-			
	in 24 hou in 24 hou he Funer pletaly fill	29a. Certifier  (Check only  2   Medical Examiner: On the besis of examinetion	ige, death occurred at the time, date end place, a end/or investigation, in my opinion, death occurr	and due to the ceuse(s) and menner as steted. ed at the time, date and place, and due to the cause(s)
	within 2 To the I complet	and manner steted.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	5 × 5 8	00 00 000	1 (V) 10185	
	(2)	1 Sullenew N	20107	- acomstal citted
K	$\langle (3) \rangle$	30 Name and address of person who completed cause of death (item 23)	e) (Type, Print)	2 DECEMBER 272004 Pel Hights MeMD 20781
		31. Date filed (Month, Day, Year) 2. Registrer's Signature	us your soury	1 x Lutantinime p cli
	State Registrar	DEC 2 9 2004	Secole)	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22, 2004 **Physician** December Da Pinto Burns 1315 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 20,1928 9. Birthplace (State or Foreign Country) Washington DC 1 □ M 2 □ XF Director 579-48-0079 76 Usual Residence of Decedent death with the Maryland 10a, State 10b. County irel", or items 23e or 28e-f show Examiner must be nutified at 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Annapolis Completed by Funeral Director 1 □ Xes 2 □ No 10e. Street and Number 10f. Zip Code 21401 10g. Citizen of What Country?
U.S.A. 907 Yardarm Lane 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Insert of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Itel Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 XWidowed 4 ☐ Divorced Specify: of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Neudical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Utilities 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Emidio Pinto Antonia Marie Cestone 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Zimmerman (Sister) 5009 Yorkville Road Camp Springs, Maryland 20748 20a. Method of Disposition
1 ÄBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. Date 20c. Location · City or Town, State = 5 Department of Importent: If eny injury or once. Resurrection Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 2004 21. Signature of Fufferal Service Litensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clitnon, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemic disease or condition resulting in death) >2 da /Medical Due to (or as a consequence of): Examiner 16 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Dualto (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) Day Year Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Shoc certificate 5 e ptic 25. Was case reserved to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Certification; To 1 ☐ Yes 2 No Other: this 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1. Natural 2 ☐ Accident 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the F 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Report T Person Mn A NO 31. Date filed (Month, 32. Regitrar's Signature State 2004 Registrar

Moorn Day   Moor				For State Registrar	State of Maryland	-	artment tificate			d Ment	al Hygie	711114	42	447
Principle   Prin		/Medi	cal	Margaret Al	myra Brown		4b. City, T	own, or Lo	cation of De	De	ionth	26, 200	1 1:	e of Death
The company of the		Funeral	lei	5. Social Security Number 6. Se	x 7. Age (In yrs. la ☐ M 2127 F		If Under 1	Year If	Under 24 H	lin. (A	Nonth, Day, Ye	9. B	irthplace (Sta Country)	
The property of the property o		Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City							<b>,</b> 1212:	10d. Insid	e City Limits Yes 2 \( \subseteq No
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The second part of Deposition		be filed within tal Hygiene. od other than "	Be	Elementary/Secondary (0-12)  11 HS Grad  17. Father's Name (First, Middle, Last)	Coilege (1-4or 5+)	Off		Cler	k/tyr . Mother's N	oist Name <i>(Fir</i> s		den Sumame)		any
23. Fart Lefter the diseased, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Part Lefter the diseased, or complications that caused the death. Do not enter the mode of ying, such as cardiac or respiratory arrest.  Approximation and the such as a consequence of the part of the pa		Pages 1 and 2 shent of Health and nt: If item 27 is mry or other traum		19a. Informant's Name/Relationship (T)  Patricia Brown  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ 1	Pomoval from State	19b. Mailin 509 ace of Disponentery, crem	Sout sition (Name natory or oth	h Fo	Number or ourth	Rural Rou Str Date	te Number, Ci eet 1 200	ity or Town, State, Denton, c. Location - City o	Zip Code) Maryl or Town, Stat	and
The standard of the standard o	Balt	permit. Depart Import eny inj		23a. Part 1. Enter the disease, or comp	lications that caused the death.	1	2 Sout	h Second of dying, s	cond S	Stree	t, Deni		Approxi	mate Between
FFEMALE:   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1		Medical Examiner  hysician and the priral-transit	icai	disease or condition resulting in death)  Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bue to (or as a consequence.  Due to (or as a consequence.	ence of):	Arto	ry	Dis	casi	re e		10	YRS
25. Was case referred to medical examiner?  1	Box 6	the death certific / the attending pl ched for use as t	ysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3								Year
25. Was case referred to medical examiner?  1	<u>α</u>	squires that ten signed by	by	Part II. Other significant conditions co	ntributing to death but not result INSUFF	Iting in the ur	nderlying cau	use given i	n Part I.	2				_
The property of the property o	al Reco				vasaelas	des	icas	e		1	autopsy performed Yes 2	prior to death?	completion	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of carrier and title of carrier and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	o	ling Phys I. After this Iuneral di	ToB	examiner? 1   Yes   No  27. Manner of Death   Natural   5   Pending	28a. Date of Injury	28b. Time of	280	Other: c. Injury at Work?	4 Nursing	g Home	5 🗌 Residence		ecify)	
30. Na B and address of person who completed cause of death (Item 23a) (Type, Print)  Andrea Allen, M.D., 219 South Washington Street, Easton, Maryland	Divis	pitel or Atte		4 Homicide determined	building, etc. (Specify)	)				C	ity or Town, S	tate)		lumber,
Andrea Allen, M.D., 219 South Washington Street, Easton, Maryland	)	To the Hosy within 24 ho To the Fune completely fi	Medical	(Check only 2   Medical Exam	ner: On the basis of examinati	vieage, death ion and/or inv	estigation, in	n my opini License nu	on, death or imber	ace, and duccurred at t	the time, date	and place, and du	e to the caus	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		St	ate_	Andrea Allen.	M.D., 219 So	outh		ngto	on St	reet	, Eas	ton, Ma		

			For State Registrar	State of	Maryland		artment of F		ind Me		jiene 10 No 0	04	42448
	Dhamist		Decedent's Name (First, Middle,					-	2	. Date of Dea Month	th Day	Year	3. Time of Death
-	Physicia /Medic			GOLD	IE MAY	BUR					6, 20	04	5:00 A M
	Examin	er	4a. Facility Name (If not institution,  LOOKABOUT MAN	1OR				TZNIN	ER		CAR	ROLL	-
	Funeral Director		218-34-0943	5. Sex 1 □ M 2 X F	7. Age (In yrs. Ia 85		Months Days	If Under 2 Hours	Min. 8	Date of Birth (Month, Pay 9 / 8 / 1	9 <sup>1</sup> 9	9. Birth	place (State or Foreign ntry) YLAND
and	W.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
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th the	or 28a-f show	)irec	10e. Street and Number		- '		10f. Zip Code		-		10g. Citizen o	of What Cou	ntry?
ath w	s 23e	rai	2842 CEDARHUI				2104		. 2 / 2		USA		
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permit. P			* 4 □ Donation 5 □ Other (So. 21. Spnature to Fundral Service Li			22	2. Name and Addre	ss of Facility	FLE'	TCHER	FUNE	RAL H	
			23a. Part1. Enter the Isease, or c shock, of the failure. List o	complications that ca	used the death.							IX, III	Approximate
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pel	ısit	niner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (c	r as a conseque	ence of):							
be execu	hysician and the burial-transit	ai Examin	that initiated events resulting in death) Last	c Due to (c	or as a conseque	ence of):							
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e death cert	the attendin hed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		th 2 Fetal on the state of dealers	death 3[	Ectopic pregnancy Other (specify)	/				Date of delive Month	ery Day Year
DIVISION OF What meetings, I.V. DOX 007 007, U.S. DOX 007 007, or the Hospital or Attanding Physician: The law requires that the death certificate be executed	within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the altending p completely filled in by the funeral director, page 2 should be detached for use as	by	Part II. Other significant condition	s contributing to de	ath but not resul	ting in the u	nderlying cause giv	en in Part I.			bacco use co		he cause of death?
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or Attar	after dea Diractor J in by the	Certification;	3 Suicide 6 Could no determin	286. Place	of Injury - At hon g, etc. <i>(Specify)</i>	ne, farm, str	eet, factory, office		281	f. Location (Si City or Town		mber or Rura	al Route Number,
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	CA	•	PHILIP J. RUZ 31. Date filed (Month, Day, Year)	BARSKY,	MD 12 gistrar's Signatu		RPORT D	K., W	VEST!	IINSTE	K, MI	0. 21	158
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician C1:00 A.M DELEMBER 18,2004 LOIS A. Haley Butts /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hospita1 Glen Burnie North Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🙀 F Director 114-26-9916 7 1933 Tennesse Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tyes 2 □ No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 USA 7836 Citadel Funeral Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ğ 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7: h and Mental Hygiene. 7 Is markad othar than "n Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) 12th Teacher 4 yrs. Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zeona Hatcher Simon Haley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If itam 27 Is m any injury or othar traum once. <u>Phillip Butts (Husband)</u> 7836 Citadel Drive Severn, Md. 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) p⊋8 brial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Memorial 4 ☐ Donation 5 ☐ Other (Specify) Cardens 22. Name and Address of Facility 12/28/04 Davidsonville, 21. Signature of Funeral Service Licensee Zaa. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUELOMA Physician MULTIPLE /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequanta of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ANo Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknow Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tyes Division of Vital Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No N⊒ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To tha Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. 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Registrar

DEC 2 2 2004

Amended #19b, nls, 12/27/04, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mental Hygiene

For	State of Maryland / Department of Health and
State Ragistrar	Certificate of Death

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Physician
/Medical
Examiner

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permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturely, or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Med Exam

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death,
To the Funeral Director: After this certificate has been signed by the attending physician and 5 かん

	1 - State Ragistrar			Cen	tificate of	Death		Ra	g. NG. U	UH	42451		
	1. Decedent's Name (First, Midd	ile, Last)					Date of Death     3. Time of Death						
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er		eart Hos	pital		4b. City, Town,	oerl	and		4c. Count	egany			
	5. Social Security Number 215–18–8125	6. Sex 7. 1 □ M 2 <b>X</b> F	Age (In yrs. last	Yrs.	Months Days		Min.	Date of Birth (Month, Day, B. 28,	<sup>Year)</sup> 1911	9. Birthp Cour WEST	place (State or Foreigntry) VIRGINIA		
	Usual Residence of Decedent  10a. State 10b. Count	W	10c. City, T	own or Loc	otion						Od. Inside City Limit		
Director		NERAL		RT A				1 🗆 Yes					
lre	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?		
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Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Ma.	12. Was Decede Armed Force rried 1 \( \text{Yes} \) 2	ent Ever in U.S. es? [X.No	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							ean Indian, etc.		
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10	DANIEL HOME  19a. Informant's Name/Relation			19b. Mailing	Address (Street		ZABE er or Rural F		OWN City or Town	. State. Zic	Code)		
	CHARLES A. KES	NER/GREAT,			BOX 76	5 <b>S</b> P		-					
	20a. Method of Disposition  1 △ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (3)	3 □Removal from Sta Specify)	ate ceme	atery, crem	tion (Name of atory or other pla Y CEMET]		Dat 2/27/2	_	Dc. Location FORT				
	21. Signature of Funeral Service	0 1	unch)	22.	Name and Addre	ess of Facility H FUNE	RAL H	OME, IN	ic.	267	10		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximation for the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximation for the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximation for the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.												
	Due to (or as a consequence of):										3 days		
Examiner	Due to (or as a consequence of):  Due to (or as a consequence of):  ANOREXIA  Due to (or as a consequence of):										3 days		
lan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal dea	ath 3□E	ctopic pregnanc	y			1	ate of delive	ory Day Year		
Physicia	1 ☐ Yes 2 ❷No 9 ☐ U⊓known	9□ Unknow	n	t time of death 5 🗆 Other (specify)						Month Day 198			
þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1   Yes 2   No 3   F										ne cause of death? ably 4 □Unknown		
Completed								24a. Was an autopsy performe	ed?	prior to cor death?	psy findings available appletion of cause of 28 No		
a	25. Was case referred to medica	al				26. Place	of Death	heck onlone					
O.B	examiner? 1 ☐ Yes 2€No	Hospital: 1 Linp	atient 2□ER/	Outpatient	3□ DOA Ott	ner: 4□ Nur	rsina Home	5 🗌 Residen	ce 6 🗆 Oth	ner (Snecifi	/)		
tion: T	27. Manner of Death  1. Natural 5 Pendi 2 Accident invest	28a. Date of I		b. Time of Injury	28c. Injur	v at	280	Describe how			7)		
Certificati	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At home, etc. (Specify)	, farm, stree	et, factory, office		28f	Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Number,		
Medical	29a. Certifier 1 Cartifyi (Check only 2 Madical one)	ng Physician: To the be Examinar: On the basi and manner	s of examination	dge, death o and/or inve	occurred at the tir stigation, in my o	me, date and opinion, deat	d place, and th occurred	due to the cau at the time, date	se(s) and ma e and place,	anner as st	ated. the cause(s)		
W	29b. Signalate and title of certifie	er D	-0		29c. Licens				I. Date signe				
	30 Name and address of person	· Muly go	of death (from 33)	2) (Type P		1377	14	DE	CEMBI	ER 2	4,2004		
	PAUL T. LI	VENGOOD n	nD 91	2 SE	TON DR	IVE	Cum	B ERLI	AND	MAR.	YLAND 245		
ite ar	31. Date filed (Month, Day, Year, DEC 2 7 20	04 32. Regi	istrar's Signature	9	fond.	,							

Registrar

			1- For Amend Item 26 State of Maryland Department of Per Verb., G840, Department of Per Verb.	artment of Health and M rtificate of Death	lental Hygie		42451	
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	Physici /Medi		La Verne Denise Brooks			Day Year / 200		
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 **	4c. County of Death		
			7814 Hanover Parkway, Apt 304	Green beit		Prince George		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye			
	Director		214-70-6509 1 M 20F 48 Yrs.  Usual Residence of Decedent		69/22/	56 M	aryland,	
	land ow		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits	
	Mary -f sh	ţō	MD Caroline Pr	reston			1 ☐ Yes 2√☐ No	
	r 28e	lrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	Country?	
	h witi	Funeral Director	21575 Wood Wharf Road	21655		nited S		
	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Am	erican Indian,	
9	or ite	F	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto f  1 ☐ Yes 2 ☐ No Specify:	Hican, etc.)	Black, Wh		
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28e-f show ta Medical Ers. if er mat be neithed	d by	3 ☐ Widowed 4 Divorced Year or Dates:	TO TOS ZEDITO Specify.		Specify:	BLACK	
5	"net	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of workir DO NOT use retired)	ng 16b	. Kind of Busines:	s/Industry	
12	withir ane. then	d m		se's Aide		ealthca	are	
	Hygid Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)		(First, Middle, Maio			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28e-f show or other treumatic event. If a Medical Era in errors to medical and or other treumatic event.	To Be	Tilghman R. Brooks	Arminth	na Sarah	Hubbai		
Mar	12 sho h and 7 is ma			ng Address (Street and Number or Rura				
	1 and Health em 27 ther tr		Kim Brooks/ Sister 2156  20a. Method of Disposition 20b. Place of Dispo	55 Dover Bridge	-	Location - City o		
Baltimore,	Pa ant Lry		1 ⊈Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)  **Commetery, cremoval from State**  **Mt. Plea	natory or other place) asant Cem. 12/18	3/04 Pr	eston,	Maryland	
Bal	permit. Pa Depurtmen Important any njury once.		Tuttoute	$^2$ . Name and Address of Facility $ { m Fr}  a                  $	, redera	uneral 1sburg,	Home, P.A. MD 21632	
ı.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	inal Facture			Onset and Death  2 Years	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):					
		_	Sequentially list conditions, if any, leading to immediate  b. Chronic Pan  Due to (or as a consequence of):	creatilis			11 months	
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Yeart Failure			3 4 0	
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	Jeans Pauline			2 years	
8760,	cate be e physician the buria	dicai	d Hypervolemia				2 days	
.89	g phys as the	0						
Вох	eath certific attending p for use as f	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1□ Live birth 2□ Fetal death 3□	Teatania autoria		23d. Date of de	livery	
	deal	sick	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year	
P.0	that the de led by the a detached f	hy	9 Unknown					
3,0	res tha igned I be det	by	Part II. Other significant conditions contributing to death but not resulting in the un				o the cause of death?	
2,5	w require been sig should b	ted	hypervolemia leading to	CHF	1 Tes	2 <b>√</b> No 3□P	robably 4 🗆 Unknown	
Record	has b	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
) <u>"</u>	ysicien: The is certificate hi director, page				performed? 1 ☐ Yes 2 ☐ 1		2 □ No	
₹ <b>1</b>	icier certif rector	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death				
<b>5</b> 0	Phys r this ral di	1	1 Tes 2 No 1 Inpatient 2 ER/Outpatient		ne <del>5 Toside</del> nce 8d. Describe how in		cify) Sister's	
% 200	ding I th. : After funer	tior	27. Manner of Death  1 Anatural 5 Pending (Month, Day Year)  2 Accident investigation	Work? M 1 □ Yes 2 □ No	56. D556.D5 1.61. II.	jury occurred	Home	
Diviston	l or Attending I after death. Director: After in by the funer	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre	eet, factory, office 2	8f. Location (Street		ural Route Number,	
Ö	s after s afte	Certification:	4 Homicide Setermined building, etc. (Specify)		City or Town, Sta	110)		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, ar restigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	s stated. e to the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Mont	h Day Year)	
	⊢ ≯ ⊢ ŏ		Allen Webb, MD		!	2 /111/.	and	
7			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	/	211712	7	
			5 Allen Webb, MD 8579	D 0040274 Commerce DR.	Suite 106	, East	on MD	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Registr	ar	DEC 1 7 2004	a final second				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Mg. U 4 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Year **Physician** INTONIO 1310 CABELLON 04 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) **Examiner** PG RINCE GEORGES HOSPITAL HE JERLY MU If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) Philippines 7. Age (In yrs. lest birthday) **Funeral** 1**℃**M 2□ F 549-74-7269 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Maryland Prince George's Upper Marlboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Haack Place 20774 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1₹TVes 2□No 1964− If Yes, Give Year or Dates: 84 1 Never Married 2 XMarried Baltimore, Maryland 21215-0020 1 ☐ Yes 2€ No Specify: Specify: Filipino ð 3 Widowed 4 Divorced 84 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Master Chief U.S. Navy 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eladio Cabellon Melita Manila 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Haack Place Upper Marlboro, Maryland 20774 Salvacion Cabellon / Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01/13/05 Arlington, Virginia Arlington Nat. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
George P. Kalas Funeral Home PA 21. Signature Funeral Service Licenses 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Approximate Interval Between Onset and Death 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. **Physician** E + TENSIVE . MY O CARDIALLN FARCT

Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physiclan/Medical Examiner ed by the attending physician and detached for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CARDIA ARRES

Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the Dialetin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? should b 24a. Was an autopsy performed? Completed ate hes 1 ☐ Yes ŽÃ No 1 ☐ Yes 2 ☐ No After this certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: N⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28d. Describe how injury occurred Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1421Waturel 1 Tyes 2 TNo death. illed in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours e To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and block, and dute to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier

31. Date filed (Month, Day, Year) DEC 2 9 2004

29b. Signature and title of ceptifier

MURAMMAD

32. Registrar's Signature

1-10

29c. License number

mpleted cause of death (Item 23a) (Type, Print)

A 24 (5) (510 Kenilworth Ave. #2500 Riverdale, MD 20737

29d. Date signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** LOUISE Y. CURRAN 22, 12:20 PM DEC. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8603 PINTA ST. CLINTON PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2**X**□ F Yrs. Director 86 536-09-1819 DEC. 6, 1918 OREGON Usual Residence of Decedent with the Maryland 10a. State 10b County 10c, City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8603 PINTA ST. 20735 U.S.A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry . Pages 1 and 2 should be filed within 73 timent of Health and Mental Hygiene. fant: If item 27 is merked othar than "no jury or other traumatic event. Ite Meali Elementary/Secondary (0-12) College (1-4or 5+) 12 **SECRETARY** FED. GOV'T. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** YARDLEY LOUISE **ELMO** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANAHAN/DAUGHTER 8603 PINTA ST., CLINTON, MD. SANDRA 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If CHAMBERS CREMATORY 12-24-2004 RIVERDALE, MD. 21. Signature of Funeral Service bicensee CHAMBERS FUNERAL HOME & CREMATORIUM, P. A **M00091** 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCES Lung /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Completed by Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Yes ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 3 Probably 4 ∰Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 No 1 Yes Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 Homicide within 24 hours a To tha Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Suite 201, Bowie, MD 207/6 SEMAC 14999 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 27 2004 Registrar

Division of Vital Records, P.O. Box 68760,

		•	For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artmer <i>tificat</i>	it of He <i>e of D</i>	ealth ar <i>leath</i>	nd Me		giene Reg. No.	004	42454	
	- 5		1. Decedent's Name (First, Middle, L	ast)						2	. Date of De		V	3. Time of Death	
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	/Medic		4a. Fecility Neme (If not institution, g	ive street and numb	er)		4b. City	Town, or L	ocation of l				ounty of Deet		
		•	Collingswood Nur	sing Cent	er		Roc	kvill	.e			Mon	tgomen	ry	
	Funeral		Social Security Number 6.		Age (In yrs.	last birthday)	If Unde Months		If Under 24 Hours	Hrs. 8	Date of Bird (Month, Da	h v. Year)	9. Birt	hplace (State or Foreign	
	Director		233-62-5700	1□M 2X)F	96	6 Yrs.		,-		0	6/21/1	908		t Virginia	
	pu 🚜	}	Usuel Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	show	č	Florida Pinella	2.5		inole								1 ☐ Yes 2 🕅 No	
	28a-f	Director	10e. Street and Number		ЭСШ	Inoic	10f 7i	Code			10g. Citizen of What Country?				
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nd	tal H	Be	17. Father's Name (First, Middle, La	st)					Marth		First, Middle,	Maiden Su	imame)		
<u>Y</u>	should nd Men marke umatic	일	Harrison Cline	C D.:-1		105 14-75	A dd					Cit T	Cardo I	Tie Code)	
Maryland	12 sh h and 7 ls n traun		19a. Informant's Name/Relationship	Pa. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Numbe  13532 Cleveland Drive, Rockvil											
	1 and Health em 27 ither tr		Da. Method of Disposition 20b. Place of Disposition (Name of Dete									tion - City or			
0	Pages nent of unt: if it		1X Bunal 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  Sylvan Abbey Mem. Pk. 12/2						1201	2007	Cloom	to.	, Florida		
Baltimore,			21. Signature of Funeral Service Lit		Syl				of Facility		ple Tr			, riolida	
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	E 18.4E		23a. Pert1. Enter the disease, or co	mplications that cau	used the deat						or respiratory arrest. Approximate				
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o,	cate be executed physician and the burial-transit	Ē	resulting in death) Last	Due to (or	as a conseq	juence of):									
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9	ding p	- υ	IF FEMALE:	23c. If yes, outco	ome of preen	ancy									
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	h 2 Fete	el death 3	Ectopic p	regnancy				230	d. Date of del Month	Day Year	
	the de	ysic	1 ☐ Yes 2 ☐ Ño 9 ☐ Unknown	9☐ Unknov		Joann J	J Other (s	occity/							
P.0	The law requires that the death certific to has been signed by the attending to age 2 should be detached for use as		Part II. Other significant conditions	s contributing to dea	th but not res	sulting in the u	nderlying	cause giver	in Part I.		23e. Did t	obacco use	contribute to	the cause of death?	
Records,	uires 1 sign 1d be	d by									1 🗆 '	res 2□!	No 3∏Pr	obably 4 @Unknown	
CO	w requir been si should	Completed									24a. Was	an 2	24b. Were au	utopsy findings available	
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Vital	ification, pe	e Co	25. Was case referred to medical						26 Place o	f Death (	1 Tes		1 L Yes	2 No	
5	Physicien: this certific ral director,	To B	examiner?	Hospital: 1 🗆 Inc	patient 2	ER/Outpatier	nt 3 🗆 D	Other	. /				Other (Spe	cify)	
ō	tending Physicien: The leath. tor: After this certificate hithe funeral director, page		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occur												
ion	Attending Indeath.	atio	1 Autural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No												
Division	er de recto by th	tific	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural R City or Town, State)							ural Route Number,					
Ö	tal or rs aft al Dii	Certification:			, (-,										
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical		Physician: To the been the bee	is of examina										
	omple	Me	29b. Signature and title of certifier		n	^	29	c. License	number			29d. Date s	signed (Monti	h, Dey, Year)	
	J		1	-1/	In	4		D .	201	48		Dece	mber	2009	
-	/		30. Name and address of persen wh	no completed cause	of death (Iter	/ 1	1.1	Λ.		الماء		N	11	,	
			Steven 1	Ulinsky	911	Lus	ecll	Tre	., C	Jan.	ers bur	3 11	19		
	Sta Registi		THE COURT PARTIES AT SUBJECT AT												

			1 - For State Registrer	State of Ma	aryland / Depa	artment of F	lealth and I	Mental Hy	giene	4 42455
	LETTE	118	Decedent's Name (First, Middle, La	st)		timouto or	Douth	2. Date of Dea		3. Time of Death
	Physici /Medic		John Joseph Clea	rv				Decembe	er 22, 20	04 3:50 A <sup>M</sup>
A.	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death		4c. County of	
5.		ž.	Casey House			Rockvil			Montgor	mery
40	Funeral		5. Social Security Number 6. S	ex 7. Age XIM 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	h y, Year)	Birthplace (State or Foreign Country)
	Director		090-18-5916 Usual Residence of Decedent		81 Yrs.			04/04/1	1923	New York
	yland Iow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a Mar	tor	MD Montgome	ry	Rockville	:				1∭Yes 2☐No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w	rai	964 Farm Haven D	rive		20852			U.S.A.	
	er de	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	irs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	1943- 1966	1□Yes 2XINo	Specify:		Specify:	White
Ö	d within 72 hours after death with the Maryland Jiene. r than "natural", or tlems 23s or 28s-1 ahow It e Micdical Examiner must be notified at	ted	15. Decedent's E		16a. Deced	dent's Usual Occup	ation		16b. Kind of Busi	ness/Industry
215	within 7 ene. than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+) (Give	kind of work done of DO NOT use retired	during most of world)	king		
21	i Hygien othar th	Co		2	Elect	rical Eng			Electron	
Maryland 21215-0036	od at D 💌	Be	17. Father's Name (First, Middle, Last, John A. Cleary	)			18. Mother's Nam		Maiden Sumame)	
Ž	should be ind Menta s marked umatic ev	ဥ	19a. Informant's Name/Relationship (	Type Printl	19h Mailir	ng Address (Street			r City or Town St	ato Zin Codo)
<u>≅</u>	2 ar		Margaret Cleary,							Land 20852
re,	s 1 and of Health itam 27 other tr		20a. Method of Disposition		20b. Place of Dispo		1 1	Date	20c. Location - Ci	
E	Page nent c		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif					27/2004	Brentwood	d, Maryland
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other to once.		2 Signatur of Funetal Service Licer	1500	The second secon	. Name and Addres		Simple T		•
	207 2 2		July Le	an We					<del>-</del>	ryland 20852
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent	er the mode of dyin	ig, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	aProstat	e Cancer					Oliser and Death
	Examiner		7.55aning in assum,	Due to (or as a	a consequence of):					
	tý.	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6						
o,	an an urial-tr		resulting in death) Last	Due to (or as a	consequence of):					
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	licai	•	d						
9	eath certifica attending ph I for use as t	/Med	IF FEMALE:	23a If was automa a						
Вох	attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	
o.		ıysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	une or death 5	Other (specify)				
σ.	requires that the leen signed by th hould be detache	by Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
rds	w requires been sign should be							1 □ Y	es 2 X No 3∣	☐ Probably 4 ☐Unknown
Records	e law re has bee ge 2 sho	Completed						24a. Was a		re autopsy findings available or to completion of cause of
Ä	The ate h page	Som			2			perfor	med? dea	ith?
Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat			
of	£ £ =	To	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatier			4   Nursing no			(Specify) Hospice
	ding h. After fune	tion	1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	28c. Injury Work	yat k? Yes 2 □ No	28d. Describe n	ow injury occurred	
Division	I or Attanding after death. Diractor: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At home, farm, stre		700 2 0.110	28f. Location (S	treet and Number	or Rural Route Number,
<u></u>	al or A s after il Dira	Serti	4 Homicide	building, etc.	. (Specify)		Į.	City or Tow	n, State)	
	a Hospital 24 hours a a Funaral E letely filled		29a. Certifier (Check only 2 Medicel Exam	ysicien: To the best o	f my knowledge, death	occurred at the tim	ne, date and place,	and due to the c	ause(s) and mann	er as stated.
	4 5 4 9	ledical	One)	niner: On the basis of and manner stat	led.					
	To To	Σ	29b. Signature and little of certifier		۸. ۵	29c. License			29d. Date signed (A	
,	18		30 No.	nomelate described	(7 <u>)</u>	D356:	35	I	December	22, 2004
			30. Name and address of person who Joseph Kaplan, MD				Rockvilla	. Marvla	and 20850	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	4		, у т.	20000	
h	Registr	ar	DEC 27 20	04 Sener	0	Sparks				

			1 - For State Registrar	State of Many		artment of F		-	jiene 0 0 L	42456
			1. Decedent's Name (First, Middle, Last	)			-	2. Date of Dea	ith	3. Time of Death
	Physici /Medic		VIOLA M	AE	CA	RTER		Month Decembe	er 19, 20	004 10:27p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	·		4b. City, Town, o	r Location of Dea	th	4c. County of	
		Щ	Holy Cross Hospita			Silver S			Montgo	
	Funeral		5. Social Security Number 6. Se	х   7.Age <i>(l</i> і ]м 2.52[F	n yrs. last birthday)  CF Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		65 Yrs.			July 3,	1939 W	ashington, DC
	ylend ylend		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Marf st	tor	D.C.	V.	lashingto:	n. D.C.				1⊠Yes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	23a	rai	1738 Swann Street,	N.W.		20	0009		U.S.A.	
	tems	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (9 an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.
36	rs afte	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	D11-
21215-0036	filed within 72 hours after death with the Marylend Hygiene. ther then "naturel", or items 23a or 28a-f show that the Mudical Examinate cust be mailied at	edt	15. Decedent's Edu		16a. Decer	dent's Usual Occup	ation		16b. Kind of Busin	Black
215	hin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wo	orking	100.11.10 01 040.1	roomingaatty
21	d with	E O	Lienientaly/Secondary (0-12)	1 Year	Food	Aide			U.S. Gov	ernment
-	be filed within 72 hours after death with the Maryler ital Hygiene.  ad other then "naturel", or items 23a or 28a-f show od other the Madical Examination is in the multipat at	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>8</u>	Mental Mental arked o	To	James Lee	U-17-7-	Carte	r	Carolyn	A	. •	Arrington
Maryland	2 short and Is m		19a. Informant's Name/Relationship (7)					ural Route Number		
e o`	permit. Pages 1 and 2 should be to Department of Health and Mental Importent: If item 27 is marked ot any injury or other traumatic even once.		Carolyn A. Carter/ 20a. Method of Disposition		3210 I		Road #219			MD 20906
Baltimore,	O or it is		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cren	natory or other plac	· 1		20c. Location - Ci	
	it. Partmer		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Lidens</li> </ul>		t. Linco					d, Maryland
Ba	perm Depa Impo any i		21. Signature of Furieral Service Literis	,						RAL HOME, INC.
			23a. Part1. Enter the disease, or comp shock, or beart failure. List only o	lications that caused the						ring, MD 20904
	Dhusisian		Immediate Cause (Final				<b>3,</b>	<b>, -</b>		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Multi Inf		entia				
	Examiner			Cerebrova	,	ccident				
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8/60,	cate be executed physician and the burial-transit	Ē	rosoning in osain/ Last	Due to (or as a co	onsequence of):					
8		dlcal		d						
×	death certiff e attending od for use as	/We	IF FEMALE:	23c. If yes, outcome of p	regnancy				23d. Date o	d delivery
X O D	that the death certif ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			Month	,
oj.	the cay the achec	hysi	9 Unknown	9□ Unknown						
7	requires that the neen signed by th hould be detache	by P	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	oacco use contribu	ite to the cause of death?
ğ	w require been sig should b		Hypertension					1 □ Y€	as 2.5xtNo 3.[	Probably 4 Unknown
ecords,		plet						24a. Was a		re autopsy findings available
I	The ate h page	Completed						autops perform	ned? dea	r to completion of cause of th? Yes 2 No
Vital	Physicien: The law this certificate has b ral director, page 2 s	Be	25. Was case referred to medical examiner?					ath (Check only on	e)	
010		ို	1 ☐ Yes 2 🔀 No	A CONTRACTOR OF THE PARTY OF TH	2 X ER/Outpatien	t 3 DOA Othe	er: 4 🗌 Nursing F	lome 5 ☐ Reside	ence 6 Other (	(Specify)
_	ing P	on:	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Injun Work	C?	28d. Describe ho	w injury occurred	
DIVISION	or Attending Phy ter death. Irector: After this by the funeral of	icat	2 Accident investigation 3 Suicide 6 Could not be	and Oliver of their	44.5		Yes 2 □ No	and the state of		
$\leq$	or Al after of Direction by	ertificati	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number ( n, State)	or Rural Route Number,
_	spital ours ours perel filled	O	29a. Certifier 1/X Certifying Phy	sician: To the best of m	v knowledge death	occurred at the tim	ae date and niace	and due to the or	Nuco/s) and mann	or an atotad
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Exami	ner: On the basis of exa and manner stated.	amination and/or inv	restigation, in my or	pinion, death occu	urred at the time, da	ate and place, and	due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (A	Month, Day, Year)
	5		gushe	MD		DO	06109	6 1	2/21/04	
			30. Name and a ress of person who co			Print) US	HA 4	OLLAI		mp
			8609 Second Avenue			yland 209	10			
N	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 7 2004	32. Registrar's	Signature	Sparks	/			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 25, **Physician** 2804 Connie Collins 1:10 A M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gladys Spellman Nursing Home Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1□ M 2√X 578 50 6194 76 Director 31. 1928 Germany Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within re.....
Iment of Health and Mental Hygiene.
Iment of Health and Mental Hygiene.
Iment of Health and Mental Hygiene.
Imental Imarked other than "natural", or items 23a or 28a-f showner. If item 27 is marked other than "natural", or items 23a or 28a-f showner.
Imental Hygiene. 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Prince George's Forestville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 3406 Springdale Ave Germany Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (T) No If Yes, Give A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 📉 o Specify: þ Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Owner 4 Antiques 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknkown ျ unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Collins (Husband) 3406 Springdale Ave, Forestville, Md 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial ACCremation 3 Removal from State
4 Donation 5 Other (Specify) Lee Crematory Dec 28, 2004 Clinton, Mayrland permit. 21. Signature of Juneral Service 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandira Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascular Disease Immediate Cause (Final disease or condition Arterwed **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical ast IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Year Day 5 Other (specify) signed by the aid be detached for P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records. 1 ☐ Yes 2 Mo 3 Probably 4 Unknown need 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an anoxic has autopsy performed? certificate ha Peripheral Vascular Disease Yes 22780 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 vursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after dec. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funeral Dir Hospital 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HyattsvilleMA 2078 eradovus. 32. Fi gistrar's Signature 31. Date filed (Month, State Registrar

			For State Registrar	State of Maryland			of Heal			iene 0	04	42458
	Physici		1. Decedent's Name (First, Middle, Last)  Robert Frank	lin Clark					2. Date of Dea Month Decemb	Day	Year 2004	3. Time of Death 6:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, To	own, or Loca	tion of Death		4c. Cour	nty of Death	
Æ.			5201 Roble Driv		ast hirthday)	Upp If Under 1	er Man	rlboro nder 24 Hrs.	8 Date of Birth			orge's
	uneral irector			IM 2□F 71	Yrs.	Months	Days Ho	urs Min.	8. Date of Birth (Month, Day April 1	,1933	0k1a	place (State or Foreign ntry) homa
and	3.2		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation						10d. Inside City Limits
Manyla	-faho fie i a	tor	Maryland Prince Geo				r1bor	)				1 □ Yes 2√ No
th the	or 28e e noti	Director	10e. Street and Number			10f. Zip C			1	0g. Citizen o	of What Cou	ntry?
should be filed within 72 hours after death with the Maryland	3 23E (	ral	5201 Roblee Dri				20772				J.S.A.	
fter de	r Itami	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ∩ 1	1	Yas Decede Yes, specif	nt of Hispani y Cuban, Me	ic Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White,	
ours al	ral', or	þ	3X Widowed 4 □ Divorced	If Yes, Give 195 Year or Dates: 195		☐ Yes 2[	XNo Spe	ecify:		Spec	cify: Wh	ite
72 h	"netu	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Decede	ent's Usual kind of work OO NOT use	Occupation done during	most of work	ing	16b. Kind of	Business/Ir	ndustry
within	rthan	отр	Elementary/Secondary (0-12)	4 College (1-4or 5+)		ineer	remedy			Gover	nment	
e filed	othar vant,	BeC	17. Father's Name (First, Middle, Last)				18. N		(First, Middle, i		ame)	
outd b	narkad netic a	10	Robert C. Clark					Dixie				
and 2 sh	7 is m treum		19a. Informant's Name/Relationship (Type Robert M. Clark						#234 St			o <i>Code)</i> hts Michigar
s 1 an	itam 2		20a. Method of Disposition		ace of Dispos metery, crem	sition (Name	e of	Janı		_	_	own, Sta <b>4</b> 8310
Pages	ant: If ury or		1 ∯Burial 2 ☐ Cremation 3 ☐ Ro '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	land V	-						Maryland
permit.	Department on return and wemen rysens.  Department on return an extract other than "netural", or frams 23s, or 28e-f show any injury or other treumetic event, the Medical Examinat must be notified at once.		21. Signature of Juneral Service License	- 1_10134	0 22.		Address of F		e Funer ia Ferr		•	c. ton, MD 2073
~	n		23a. Part1. Enter the disease, or complete shock, or heart failure. List only on	ne cause on each line					-			Approximate Interval Between
	sician		Immediate Cause (Final disease or condition resulting in death)	HYPERTER	ISIVE	CARI	10 VA	SCULA	- DISE	ASE		Onset and Death
	ledical aminer		Todaning in additing	Due to (or as a consequ	ience of):							
	1 2	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of):							
ecuted	transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
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	g phys	edical	d	l								
th cert	signed by the attending physician and d be detached for use as the burial-transit	Physician/M	230. Was decedent pregnant	3c. If yes, outcome of pregnal		Ectopic preg	gnancy			1	Date of deliv	,
e dea	the att	/sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐ Unknown		Other (spec				\ \ \ \	Aonth	Day Year
that th	ed by detac		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the un	derlying cau	use given in F	Part I.	23e. Did tot	pacco use co	nt <i>ri</i> bute to t	he cause of death?
quires	n sign uld be	ed by	DIABETES	MELLITUS					1 □ Ye	s 2 No	3 □ Prot	oably 4 □Unknown
aw re	has been si je 2 should	Completed							24a. Was a autops		. Were auto	psy findings available impletion of cause of
The	page	Com							perform	ned? 2 <b>X</b> No	death?	2□ No
ician	certific ector,	Be	25. Was case referred to medical examiner?	lospital:			Other		(Check only on			
Phys	er this eral dii	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of		c. Injury at Work?		me 5 Reside 28d. Describe ho			(y)
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or Atta	Diracto Diracto in by th	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory,	office		28f. Location (St City or Town		nber or Rura	al Route Number,
To the Hospital or Atlanding Physician: The law requires that the death certification of the Atlanding Physician:	within 24 mous arier to again.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at estigation, in	the time, da	te and place, , death occurr	and due to the ca	ause(s) and r ate and place	manner as s e, and due to	tated. o the cause(s)
To the	To the	Me	29b. Signature and title of certifier			29c.	License num	ber - A ~ ~	2	9d. Date sign	ned (Month,	Day, Year)
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NP	1100		30. Name and address of person who co A. DA SHOT TORK,	mpleted cause of death (Item	23a) (Type, F	Print) PA	TRK 1	NAY #	A. GRI	ZENBO	TIN	14.20770
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David G. Cosser Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-8306 State of Maryland / Department of Health and Mental Hygiene AKG for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2004 David G. Cosser, Jr. December 6:22 Р /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u> 3 Turtle Court</u> #D , Building Edgemere If Under 1 Year If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F Yrs. **Director** February 3, 1939 219-34-1244 <u>Maryland</u> Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ahow the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Edgemere 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or Items 23a or 3 Turtle Court #D, Building 3 21219 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White δ 3 ☐ Widowed 4 X Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Importants if item 27 is marked other than any injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 12 Steelworker Stee 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David G. Cosser, Sr. Norma L. Bailiff 19b. Mailing Address *(Street and Number or Rural Route Number, Cit*y or Town, State, Zip Code) 4925 Buck's Schoolhouse Road, Baltimore, Ma 19a. Informant's Name/Relationship (Type, Print) Maryland Carol Falkenhan/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 29, December 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)
21. Signature of Funding Service I come 2004 Bay View Cemetery Bay View, Maryland 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final criose Pnysician 6 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed use as the burial-transit and Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy erformed 24b. Were autopsy findings available prior to completion of cause of has 2 No Yes 2 🗆 No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor; 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Diracto completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide or A To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only 29d. Date signed (Month, Day, Year) 29b. Signature title of certifle 29c. License number O.C.M.E. December 25, ess of person who completed cause of death (Item 23a) (Type, Print) A KON LO CHE M 111 Perh Street, Baltimere, Maryland, 71201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 9 2004 Registrar

			1 - For State Registrar	State of	Marylan	d / Depa		t of H	ealth a	and M	ental Hyg	giene	004		+2460
			1. Decedent's Name (First, Middle, I	.ast)							2. Date of Dea Month	ath Day	Yea		3. Time of Death
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	Funeral Director		236-36-1512 Usual Residence of Decedent	1 M 2 XF	7. Age (In yrs.		Months	Days	Hours	Min.	8. Date of Birt (Month, Day March	v, Year)	9.1	Country	e (State or Foreign ) W.VA
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Baltimore,	permit. Pag Department Important: It any injury o once.		21. Signature of Funeral Service Lice	estien	'>	1	12 Wa	shir	aton	Road	and Cl	ninst			21157
П			23a. Par 1. Enter the dispase, or co shock, or heart failure. List on	mplications that ca ly one cause on ea	used the deat ch line.	h. Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory ar	rest,	.01	Ar In	pproximate terval Between
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	/Medical Examiner		resulting in death)		r as a conseq										
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Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna		Tetania ar					23	d. Date of c	delivery	
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			Registrar  1. Decedent's Name (First, Middle, Last)		Timeate of	Dealii	2. Dat	Reg e of Death	NG. UU4	3. Time of Deat	th
	Physicia		Maryanne U. Conlan				De	nth	Day Yea 6, 2004	r	P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of		2.	4c. County of De		L
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5	Pages 1 nent of h nnt: If its ury or ot		20a. Method of Disposition 1 □ Burial 2 ② Cremation 3 □ Removal from State	cemetery, crei	matory or other pla				c. Location - City		
Dalimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other traumatic evant. The Madical Examiner must be notified at once.		. 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Foneral Service Ligensee	Metropolita		-				ia, Virgir	IIA
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ה ה	aician: The law certificate has b irector, page 2 s	Completed					248	Was an autopsy	prior to	autopsy findings availa o completion of cause	of
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	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 ✓ Certifying Physician: To the best of (Check only one) 2 ☐ Medical Examiner: On the basis of and manner sta	examination and/or in	n occurred at the ti vestigation, in my	me, date and opinion, death	place, and due occurred at the	to the caus time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)	
	ro tha	Me	29b. Signature and title of certifier		29c. Licens	se number		29d.	Date signed (Mo	nth, Day, Year)	
	r>F0		I huste conto		61.	549		De	ec. 26, 2	2004	
1	5)		30 Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print)	D 1 :	11		-		
1	The same of the sa		Christine Lepoutre, 9701 Me		ter Dr.,	Kockvi	IIIe, MI	208	550		
	Sta Registr		[CLE (C) (C) (C) (1) (1) (1) (1)	ar's Signature	carl.						

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Donald Cutsail December 2004 21, 9:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2601 Kinderbrook Lane Bowie Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 ☐ F Director 254-34-9735 91 Yrs 12-13-1913 Kansas Usual Residence of Decedent death with the Manyland 10a. State 10h Count 10c. City, Town or Location 7 is marked other than "neturel", or items 23e or 28a-f show treumatic event. Ite Medical Exertinet must be nutified at 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 Kinderbrook Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, permit. Pages 1 and 2 should be filed within 72 hours after t Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or Iter any injury or other treumatic event. The Madical Eventlant Black, White, etc. 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Car Salesman Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Cutsail Lillian Garoner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Wagner Cutsail/ Wife 2601 Kinderbrook Lane Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory 12/23/2004 Waldorf, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ALZHEIMER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 8 RESSURE ULCER 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Man er of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred : After t Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 22 Cumarisparer MO 016619 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) VERBARA-SDARES LANDOVER MD. 20785 8240 PROFESSIONAL PLACE 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State DEC 22 2004 Registrar

			for - State Registrar	State of	of Maryla	-	artment of H			giene 10 (	) 4	42463
1			Decedent's Name (First, Middle, La	ist)					2. Date of Death 3.			3. Time of Death
	Physici		Robert	Josep	h		Carter		Decemb	Day	<b>Year 3004</b>	11:50 AM
	/Medio Examin		4a. Facility Name (If not institution, giv	re street and nu	mber)		4b. City, Town, or	Location of Death		4c. County		
			Lions Manor N	Nursing	Home		Cumb	erland		A 1 1	egany	v
i	Funeral		5. Social Security Number 6. S	Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign
	Director		215-16-4385	1ĂM 2□F	81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 06/29/	1923	Cour Mar	yland
	P		Usual Residence of Decedent		1							
	arylar show	_	10a. State 10b. County		10c. C	City, Town or Lo	ocation				1	10d. Inside City Limits
_	Be-f.	cto	MD Alle	gany		C	umberland					1 ⊠ Yes 2 □ No
1	hours after death with the Maryland urel; or Items 23a or 28e-f show	Funeral Director	10e. Street and Number 20 Bellevue S	Stroot			10f. Zip Code	502	1	10g. Citizen of V		ntry?
	ath v	la l		,						USA		
7	er de	nue	11. Marital Status	Armed Fo	edent Ever in orces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spa In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - Americ k, White,	ean Indian, etc.
3,6	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Gi	2 No 19 ve lates: 19	43	1 ☐ Yes 2 🛱 No	Specify:		Specify.	r: 1.71	hite
ober	ture after	ba	15. Decedent's E	ducation		16a, Dece	dent's Usuai Occupa	ation		16b. Kind of Bu		
T 2	1 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n 1 n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)	4.45-)	(Give	kind of work done of DO NOT use retired	during most of work	ring	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
7-6	d with	E	8	College (	1-40r 5+)	(	Cook			Rest	aurar	nt
\$ E	other than	Вес	17. Father's Name (First, Middle, Last	)				18. Mother's Name	e (First, Middle, I	Maiden Sumam	e)	
<u> </u>	uld bu Aents rrked	ToE	Melvin	W.	1	Carte	er	Lillian	Α.	•	Lav	vrence
arte	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Examinet Franchified at once.		19a. Informant's Name/Relationship (				ng Address (Street					Code)
	and and a salth		Elizabeth Jane I	Light/da ————		-	National		LaVale,	, Maryl	and	21502
i i i	Tite 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from	20b.	Place of Dispo cemetery, cres	osition (Name of matory or other plac	θ)	Date	20c. Location -	City or To	own, State
<u> </u>	Pag ment ant: I		' 4 □Donation 5 □Other (Specif		R		Mem. Gar				,	
<u>+</u>	permit. Departi Import any inj		21. Signature of Feneral Service Licer	nsee	1	2;				,		Home, P.A.
<u> </u>		. 10	talut C.	4 In	/	ČI.		atur Str			, MD	21502
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on	aused the dea	ath. Do not ent	ter the mode of dying	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		pointic	emi O	1				2	Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):		-				W-9S
	Examine		Sequentially list conditions,	b. U.	111							U
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):						
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c	(or as a conse	quence of):		· · · · · · · · · · · · · · · · · · ·				
8760	be e bician buria											
787	icate phys s the	dical		_ d								
, e	certif ding	Ĭ,	IF FEMALE:	23c. If yes, ou	tcome of pregr	nancy				23d Dat	e of delive	an.
Box	leath certific	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ∐Live b	ointh 2 ☐ Fei nant at time of	tal death 3	Ectopic pregnancy Other (specify)			Mor		Day Year
٥	that the de ned by the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn			<b>2</b> (-p,) <u> </u>					
Δ.	s that	by Pi	Part II. Other significant conditions of	ontributing to d	eath but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to th	e cause of death?
2	n sign		Severe C.D	PD.	felizh	line	is di	seare	1 □ Ye	s 2.ENo	3 🗌 Prob	ably 4 Unknown
ç	w require s been si should l	Completed	Princeral 1	Mincu	last	dise	ane d	upplicat	24a. Was ar	n 24b. V	Vere autor	psy findings available
ă	sicien: The law certificate has b lirector, page 2 s	mo	= DOT NOVO		Coola		) (	1 phay	autops perforn	y p nęd2 d	rior to con leath?	npletion of cause of
<u> </u>	en: ] tificat	0	25. Was case referred to medical	un.				26. Place of Death			☐ Yes	200 No
5	ysici s cer direct	To B	examiner?	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA Othe	er V	me 5 ☐ Reside		er (Specifi	<i>(</i> )
Š	ding Physicien: The Ing.  After this certificate ha funeral director, page		27. Manner of Death	28a. Date		28b. Time of			28d. Describe ho		· · · · · ·	7
<u>.</u>	tendin leath. tor: Aff the fur	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	in, Day rour	Пцагу	M 1 1 1	res 2 □No				
Division of Vital Records	Atte er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place	of Injury - At I	nome, farm, str	eet, factory, office		28f. Location (Sti City or Town		or Rura	l Route Number,
ت ت	rs aft el Dij											
	To the Hospital or Attending Physicien: The law requires that the death certification 24 hours after death certificate has been signed by the attending prother than the completely filled in by the funeral director, page 2 should be detached for use as	edical	(Check only 2 Medical Exar	niner: On the b	asis of examin	owledge, death	n occurred at the tim vestigation, in my op	e, date and place, a	and due to the ca	ause(s) and mai	ner as st	ated. the cause(s)
	the the mplet	Med		and man	ner stated.		29c. License					
	,		29b. Signature and title of certifier	. 4			11-1	10141-5	) 2	9d. Date signed		
	3/1VA		20 Name and address of assess	11Wav	o of death ():	m 93c\ /T =	Front)	17/20	/ 1	rums	UV c	28,2004
	MAS		30. Name and address of person who	Hhan	o o death (ite	517 A	Atmin	Pond Cur	nhorlar	d. MD	215	502
	Sta	te	31. Date filed (Month, Day, Year)	32. A	egistrar's Sign	ature		Nanu CM	WEST WIT	301,000	7110	
	Registr	ar	DEC 2 8 2004	64.	, res	19 1	parks					

			1 - For State Registrar	State of Maryland		rtment of H			giene 00	14 42464
			Decedent's Name (First, Middle, Last)	)				2. Date of Dea	ath	3. Time of Death
	Physicia /Medic	_	Jessie	P. Dicker	son			Dec. 2	2, 2004	6:30a. <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deal		4c. County of	
÷16				Nursing Home		Takoma			Montgo	-
	Funeral		5. Social Security Number 6. Se	TM 2NTE		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	, Year)	Birthplace (State or Foreign Country)
Ь	Director		Usual Residence of Decedent	7	/ 115.			Aug. 1,	1927 W	ashington, DC
	/land		10a. State 10b. County	1	, Town or Lo				-	10d. Inside City Limits
	Mar.	ţ	MD Prince Ge	eorges H	yattsv	ille				1X Yes 2 No
	or 28	)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	23£	Funeral Director	909 Cox Avenue			20703			United S	tates
	er deg	une	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (5 ın, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black,	- American Indian, , White, etc.
50	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2127 No If Yes, Give Year or Đates:	1	☐ Yes 21 No	Specify:		Specify:	Black
0500-c	72 hours after death with the Maryland natural; or tems 23c or 28a-f show usal Exam act must be codified at		15. Decedent's Edu	ıcation	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Busi	iness/Industry
2	hin 72 an "m Medi	ple	(Specify only highest grad	(e completed)  College (1-4or 5+)	(Give	kind of work done o OO NOT use retired	during most of wo l)	rking		,
N	filed within Hygiene. Ither than "	Completed	12th		Sta	ticstian			US Censu	us Bureau
and	m = 0 %	Be (	17. Father's Name (First, Middle, Last)					me (First, Middle,		)
<u> </u>		ဥ	Walter Pyles					Frankli		
<u>a</u>	nit. Pages 1 and 2 should artment of Health and Mer ortant: If item 27 is marke injury or other traumatic g.		19a. Informant's Name/Relationship (T) Wayne Tate	rpe, Print)		g Address <i>(Street a</i> Ashford I				tate, Zip Code)
ē,	ss 1 an of Heal item 2 other		20a. Method of Disposition	20b. Pl		sition (Name of natory or other plac		Date		tity or Town, State
Бапппо	permit. Pages Department of H Important: If its any injury or of		1 Surial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Tellioval Ilolli State		oln Cem.	12/2	7/2004	Bladensl	burg, Maryland
<u> </u>	permit. Departm Importa any inju		21 Signature of Funeral Service Licens	ee (1/A)	22	Name and Addres	e of Equility			neral Home
מ	Dep Impe		Luciu	mille	30	15 12th S				20017
	*		23a. art1. Enter the disease, or complishock, or heart failure. List only o	lications that cause the death ne cause on each line	. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory an	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, M	111 m	mea				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ince of):	- 10	24			
		<u>_</u>	Sequentially list conditions,	b. Due to lor as a consenu	all	Whimi	a	. 1		
-	ited nsit	Examiner	Sequentially list conditions, and to the cause. Enter Underlying Cause (Disease or injury	M	ntro	to this	Valor	est an	la ·	
,	execun n and ial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):	alle —		777		
20	certificate be executed ding physician and use as the burial-transit	cal		d						
9		Jedi	IF FEMALE:							
X D D	th ce tendii or use	an/I	23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date	
	e death the atten ned for u	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5	Other (specify)			Monti	h Day Year
Ţ.	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the un	iderlying cause give	en in Part I	23e Did to	hacco use contrib	oute to the cause of death?
as,	signe d be	d by	Malulén	Mala, to		additying databa give	or are are a			Probably 4 Onknown
cords	v requ	ompleted	- June	1 warm				24a. Was a	245 146	auto-su findings available
ď)	e las has	dm						autop:	sy price dea	ere autopsy findings available or to completion of cause of ath?
	iclan: Th certificate rector, pag	င္ပ	25. Was case referred to medical				00 Di		212 No 1 E	Yes 2000
>		0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3 □ DOA Othe		ath (Check only or Home 5□ Resid		(Specify)
0	g Phys er this seral di	n: T	27. Manner of Geath		28b. Time of Injury	28c. Injury Work			ow injury occurred	
SION	Attending Predath. ector: After i	atlo	1 Datural 5 Pending 2 Accident investigation	(Month, Day 10al)	nijury		Yes 2 □ No			
<u>=</u>	r Atterde	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
2	spital or ours afte neral Dir filled in	0		1				1		
	Hos Fur Fur tely	edical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medicel Exemi	sician: To the best of my knowner: On the basis of examination and manner stated.	wiedge, death ion and/or inv	estigation, in my op	ne, date and place pinion, death occu	e, and due to the c urred at the time, c	ause(s) and mann late and place, an	er as stated. d due to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	./		29c. License	number	2	29d. Date signed (	(Month, Day, Year)
			) In a	W		6	614	7	1212	7105
N	(5)		30. Name and address of person who co	ompleted cause of death (Item			011			
1			Nasreen Kun	GO 7610 22. Registrar's Signat	Car	OllA	re Tail	Koma P	K MD	20912
	Sta Registr		nec 2 9 2004	- Registrar's Signar	Lan	6,				

			1 - For State Registrar	State of Marylan	d / Department of F Certificate of		Hygiene () ()	4 42465
	Physic /Medi Exami Funeral Director	cal	377-24-3079	MAE e street and number) F+WASH	Fort	If Under 24 Hrs. 8. Date of Hours Min. (Month,	Death  Ac. County of  Birth  Day, Year)  9.	Birthplace (State or Foreign
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, If a Mudicul Examiner must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD Prince G  10e. Street and Number  6919 Taylor Manor  11. Marital Status  1 Never Married 2 Married  3 Moriod 4 Divorced  15. Decedent's Ed  (Specify only highest grave)  Elementary/Secondary (0-12)  12th  17. Father's Name (First, Middle, Last)  Benjamin Robinso	Avenue  12. Was Decedent Ever in U. Armed Forces? 1 \( \text{Tyes} \) 2 \( \text{DN} \) to if Yes, Give Year or Dates:  ucation de completed)  College (1-4or 5+)	Avenue  2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:  ation completed)  College (1-4or 5+)  10f. Zip Code  20748  13. Was Decedent of Hispanic Origin? (Specify Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 Yes, Specify Cuban, Mexican, Puerto Ricar 1 ☐ Yes 2 ☑ No Specify:  ation (Give kind of work done during most of working life. Do NOT use retired)  Laundry Worker  18. Mother's Name (First			10d. Inside City Limits  1½ Yes 2 No  1 Country?  American Indian, White, etc.  Black ess/Industry  ment
	permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once.		19a. Informant's Name/Relationship (7 Joyce A. Walker/  20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify  21. Signature of Lineral Price Licen.	Daughter  Removal from State  Ft.	604 Harry S  Tace of Disposition (Name of ametery, crematory or other place).  Lincoln Cemet 22. Name and Addres	ery 12/31/04	er Marlboro 20c. Location - City Brentwood nkins Funer	, Maryland or Town, State , Maryland cal Home
8760,	death certificate be executed  Wedgical and was as the burial-transit  Medical as the burial-transit	cal Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. CONCEST!  Due to (or as a consequ	Do not enter the mode of dying  VE HEART  Jence of):  NSI DN  Jence of):	g, such as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
P.O. Box 6	law requires that the death certificat as been signed by the attending phy 2 should be detached for use as th	leted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions co	23c. If yes, outcome of pregnar 1  Live birth 2  Fetal 4  Pregnant at time of de 9  Unknown	death 3 Ectopic pregnancy eath 5 Other (specify)	1[		Day Year  e to the cause of death?  Probably 4 □Unknown
Division of Vital Records,	Physician: The la this certificate has al director, page 2	Certification: To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year)	28b. Time of lnjury Work  M 1 Y	pe   1   Yes   26. Place of Death (Check online   4   Yes   26. Place of Death (Check online   5   Reat   28d. Describ   28d. Describ   28f. Location   28f. L	itopsy prior death s 2 No 1 N	res 2 □ No pecify)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	Medical Ce	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	and manner stated.	vledge, death occurred at the time on and/or investigation, in my op	nion, death occurred at the tim	e, date and place, and d	onth, Day, Year)
	5 Sta		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print) ROAD STE, 500		DEC 27 MD 207	

			1 - State of Maryland / Department of Certificate of Maryland		ental Hygier	2004	4246	б	
	Dhinis		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Deat	th	
	Physici /Medio		William D. Donlon		21, 2004	2:35 A	М		
	Examir	er		vn, or Location of Death	4	c. County of Death	_		
			Heritage Harbour Health & Rehab.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yo	Annapolis Tear   If Under 24 Hrs.   3	Data of Birth	Anne Ar			
г	Funeral Director			ays Hours Min.	8. Date of Birth (Month, Day, Yea Dec. 29		place (State or Fore ntry)	aıgn	
	D		Usual Residence of Decedent		Dec. 29,	1911 New	York		
	anylar show	2	10a. State 10b. County 10c. City, Town or Location			1	10d. Inside City Lim		
	the M	Director	Maryland Anne Arundel  10e. Street and Number 10f Zin Coo	Odenton	1		1 □ Yes 3/5		
	with with	Di	2495 Amber Orchard Ct. East #304	21113	10g. C	Citizen of What Cour	ntry?		
	death ms 2; Crows	Funerai		of Hispanic Origin? (Spec Cuban, Mexican, Puerto Ri	ify Yes or No-	14. Race - Americ	can Indian,		
စ္	after or ita		1 Never Married 2 Married 1 Yes 2 D No		ican, etc.)	Black, White,	etc.		
21215-0036	72 hours after death with the Maryland retural; or Itams 23a or 28a-f show dical Examiner must be motified at	d by	3 ☑ Widowed 4 □ Divorced	No Specify:		Specify: W.	hite		
15-	n 72 ł	Completed	15. Decedent's Education 16a. Decedent's Usual October (Specify only highest grade completed) (Give kind of work of life. DO NOT use re	one during most of working	16b.	Kind of Business/Inc	dustry		
12	within iene.	ошр	Elementary/Secondary (0-12) College (1-4or 5+)  Administ			Power Com	nanv		
b	be filed within 72 hours after death with the Marylan ntal Hygiene. sd other then "natural", or itams 23a or 28a-f show avant, the Medical Evandret must be redified at	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (			parry		
/lar	uld be Mental irked c	To B	Louis Donlon	Lena Er	lemeyer				
Maryland	ges 1 and 2 should be it of Health and Mental If itam 27 is marked or or other traumatic av		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Str	reet and Number or Rural i	Route Number, City	or Town, State, Zip	Code)		
	0 = 12 =		Judith G. Donlon Wacker/daughter 2495 Amber					13	
altimore,	ages 1 t of H : If ita		20a. Method of Disposition  1X2Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other	place)		Location - City or To			
Ħ	urtmer prtant njury		'4 □Donation 5 □Other (Specify)  21. Signatur Funeral Service Licensee  22. Name and Ac	1		ssapequa,		K	
Ba	permit. Pages 1 an Department of Heat Important: If itam 2 any injury or other once.	1 10	Found & Willer 147 Duke	of Glouceste	er St. A	or Funera nnapolis,	и ноте мо 21401	1	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac or i	respiratory arrest,		Approximate Interval Between		
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Malignant bite due resulting in death)	ct tumor			Onset and Death		
	Examiner		Due to (or as Monsequence of):						
	Degree 1	er	Sequentially list conditions, if any, leading to immediate						
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
Ó,	an an irial-tr	Exa	resulting in death) Last Due to (or as a consequence of):						
8760,	cate be executed physician and the burial-transit	dicai	d						
9	ding p		IF FEMALE:						
Вох	The law requires that the death certifit to has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1			23d. Date of delive Month	ry Day Year		
P.O.	the d y the sched	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify, 9 ☐ Unknown	7					
	res that signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?		
Records,	w require been sig should b	ed b	Cerebrovascular disease		1 ☐ Yes 2	No 3□ Proba	ably 4 □Unknov	wn	
eco	ne faw requ has been ge 2 shouk	Completed	Coronary Artery disease		24a. Was an	24b. Were autor	osy findings availat	ble	
_		Com			autopsy performed? 1 ☐ Yes 2 ☑ No	death?	npletion of cause o 2□ No	)T	
Vital	ysician: Th	Be (	25. Was case referred to medical examiner?	26. Place of Death (0					
o	Phys this al di	10 10	Thipatient 2 Ervoupatient 3 DOA			6 ☐Other (Specify	)		
uo	tanding I leath. tor: After the funer	tion	1 Natural 5 Pending (Month, Day Year) Injury V	njury at 286 Work? 1 ☐ Yes 2 ☐ No	d. Describe how inju	iry occurred			
Division	= 0 0	fica	3 Suicide 6 Could not be 28e Place of Injury. At home farm street factory office		Location (Street a	nd Number or Rural	Route Number		
	al or a after a Dira	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Stat		riodio validos,		
	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: Atter completely filled in by the fune.	edical (	29a. Certifier (Check only and)  29 Medical Examiner: On the best of my knowledge, death occurred at the and of examination and/or investigation, in m	e time, date and place, and	due to the cause(s	i) and manner as sta	ated.		
	thin 2 tha tha mplet	Med	and manner stated.						
)	W Y			29/93		ate signed (Month, E			
		-	20. Name and address of person who completed equal of death (to - 22-) (Time - Bi-r)			imber 21,	ZCOF		
			Stephen Killian MD. 3169 Braverton St. 1  31. Date filed (Month, Day, Year)  DEC 22 2 7 ND4  32. Prostrar's Signature	#201 . Edee	water M	0 21037			
- 24	Sta	-	31. Date filed (Month, Day, Year) 32. P gistrar's Signature	, ,					
1 2	Registra	ar	DEC 2 2 2004 Brew & April						

			1 - For State Registrer	State of M	aryland / Dep Ce	partment of F ertificate of	lealth and N Death		iene 004	42467		
	Physici /Medi		1. Decedent's Name (First, Middle, La Shirlie	ist)	Elizabeth	Day		2. Date of Deat Month Decembe	Day Year	3. Time of Death 4 5:40 A M		
	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea			
* 90			Memorial Hospita			Cumbe			Allega	-		
	Funeral Director		217-28-7565		9 (In yrs. last birthda) 7 4 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/27/1	9. Bii 930 Mai	thplace (State or Foreign ountry) Cyland		
	yland		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
	Ba-f st	ctor	MD Alleg	any		Cumberlan	d	_		1 Yes 2 □ No		
	3s or 21	I Dire	10e. Street and Number 8 Decatur	Street		10f. Zip Code	1502	10	g. Citizen of What C	ountry?		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any njury or other traumatic event. Ite Medical Evantual must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 2 1 If Yes, Give		. Was Decedent of H If Yes, specify Cub		pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, etc.		
9	2 hour atural	ted b	15. Decedent's E	Year or Dates:	16a. Dec	edent's Usual Occup	pation		6b. Kind of Business	White		
Maryland 21215-0036	vithin 7. ne. han "n	Completed	(Specify only highest gi	rade completed) College (1-4or 5	(Giv	e kind of work done DO NOT use retire Homema	during most of work d)	ring				
d 2	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Las	HOMEM:	Homemaker							
/lan	uld be Mental Irked o	To Be	Unknown				Merle		da	Day		
Man	12 sho h and l risma		19a. Informant's Name/Relationship						City or Town, State,			
	tem 2		Sheila Scholze ,		20b. Place of Disc	osition (Name of			Cumberland Oc. Location - City or	d, MD 21502 Town, State		
<u>=</u>	Page: nent o ant: If ury or		1 ☐ Surial 2 ☐ Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Speci		Sunset M	ematory or other place emorial P	ark   12/3		Cumberla			
Baltimore,	permit. Departi Importi any inji		21. Signatu e of Juneral Service Lice	Masure					ly Funeral erland, MI	Home, P.A. 21502		
Ü	<b>*</b>		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final									
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		iratory Fa	ilure				11 days		
	Examiner		Sequentially list conditions		ce COPD					several		
	ped sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):								
60,	be execu ician and burial-tra		that initiated events resulting in death) Last	cDue to (or as	a consequence of):							
68760,	g phys as the	edical	`	d								
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of del Month	ivery Day Year		
Records, P.O.	ires that I signed by d be deta	I by Ph	Part II. Dther significant conditions Non-transmura	contributing to death bi	ut not resulting in the	underlying cause giv tion	en in Part I.		acco use contribute to	the cause of death?		
COL	w requ	letec						24a. Was an		topsy findings available		
al Re		Completed						autopsy perform 1 Yes 2	prior to death?	2 No		
Vital	sician: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/Outpatie	ent 3 DOA Oth	26. Place of Death					
Division of	ding Phys h. After this funeral di	on: To	27. Manner of Death  1XXNatural 5 Pending	28a. Date of Injur (Month, Day				me 5 Hesider 28d. Describe hov	ce 6 Other (Spec vinjury occurred	orly)		
Siol	Attendir death. ctor: Al y the fu	icatlo	2 Accident investigation 3 Suicide 6 Could not be	n e		M 1 🗆	Yes 2 □ No					
N	ital or Attenders rs after death ral Director: led in by the	Certification:	Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route City or Town, State)									
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying PI (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or ii	th occurred at the tin nvestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)		
	To t To t com	Σ	29b. Signature and the of certifier	Off	Maa	29c. License			d. Date signed (Mont)			
•	5	-	30. Name and address of person who	completed cause of d	eath (Item 23a) /Tuna		018216		12/30/04			
	nh		Steven 1	2 Smith		00 Seton I	Orive, Cur	mberland,	MD 2150	2		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 0 200	32 Registra	ar's Signature	porks	/					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** 10PM DONALD AROL 33 04 12 /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Apt 807 Baltimore Avenue Hagerstown If Under 24 Hrs. 8.1 Washington 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex Funeral Months Deys Hours 1□M 2 F 215-40-1664 62 Maryland Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours aftar death with the Marylend Department of Health end Mental Hygiene. Department of Health end Mental Hygiene "Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. Stete 10c. City, Town or Location 10d. fnside City Limits 10b. County 1 Ñ Yes 2 □ No Washington Hagerstown **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 11 Baltimore Avenue, Apt 807 21740 Race - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by White 3 ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Pharmacy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Leon Lewis Charlotte Tipka McIntosh 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Route 1 Box 140-A1, Keyser, West Virginia 26726 Julie Weaver / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 12/27/2004 Cumberland, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral nome, 21. Signature of Funeral Service Licensee 21502 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Metastatic 8-9 mont Examiner Due to (of es a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within £4 hours elater death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completaly filled in by the Inneral director, page 2 should be detached for use as the buriat-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Dfd tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☑ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☑ No 1 🗆 Yes 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28c. fnjury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier Walnut Street Community Health Center 2 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Walnut Street Family Practice MLS 24 N Walnut Street, Suite 102 CAURA 也 MiD 32. Registrer's Signature Hagerstown, MD 21740 31. Dete filed (Month, Day, Year) DEC 2 2004 Registrar

		•	For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H <i>te of L</i>	ealth a Death	and Me		gien Reg. N		4	42	469
	Dh		1. Decedent's Name (First, Middle, La	st)							. Date of De		av od	Year		of Death
	Physici /Medic		Benjamin Epps J	r							ECEMB1	ER I	ť7, 2d	004	9:15	) Р м
	Examin		4a. Facility Name (If not institution, giv		ber)		1 -	r, Town, or LTIMO				1	c. County of		0	
			2520 N CHARLES 5. Social Security Number 6.5		Age (In vrs	last birthday)		er 1 Year	If Under		Date of Bir		Baltin		Co.	te or Foreign
	Funeral Director			I XM 2□F	. Age ( <i>m yrs.</i>	Yrs.	Months		Hours	Min.	Date of Bir (Month, Da July 1	y, Yea	1949 V	Cour	inia	e or roreign
٠.			Usual Residence of Decedent								,ury r	-,	1010 1			
	how		10a. State 10b. County		10c. Ci	ty, To <b>wn</b> or Lo	cation							1		City Limits
	e Ma	to	MD Baltimor	e Co.	Ba1	timore									1 [ <u>3</u> [[]	es 2 No
	or 26	Oire	10e. Street and Number					ip Code					itizen of Wh	nat Cour	itry?	
	ath w	Funeral Director	2520 North Charl	T .		_		218					USA			
	items items	nue	11. Marital Status	12. Was Deced	es?	l.S. 13.	Was Dec	edent of Hi ecify Cuba	spanic Ori n, Mexicar	gin? (Speci n, Puerto Ri	fy Yes or No can, etc.)	)-	14. Race - Black,	- Americ White,		1
36	rs aft	Jy F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dat	1		1 🗆 Yes	2 <b>□x</b> No	Specify:				Specify:	B1a	ck	
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68760,	icate be execufed physicien and s the burial-transif	edicai	•	d												
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Вох	eath certifi attending   I for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live bir	th 2 Feta	aldeath 3	Ectopic Other (	pregnancy					23d. Date Month		Day	Year
P.0.	the d	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknov		304117	3 0000 (	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
	The law requires that the death certit afe has been signed by the attending page 2 should be detached for use a		Part II. Other significant conditions	contributing to dea	ath but not re:	sulting in the u	nderlying	cause give	n in Part I		23e. Did t	obacco	use contrib	ute to th	ne cause o	of death?
Records,	n sign	d by									10	Yes :	2 □ No 3	Prob	ably 4	□Unknown
00	s been shoul	Completed									24a. Was		24b. We	ere auto	psy findin	gs available
Re	fhe lav fe has age 2	mo									autor perfo	rmed?	de	ath?	mpletion o	of cause of
ta	en: tifica tor, p	0	25. Was case referred to medical						26. Place	of Death (	Check only		12	<u>, 100</u>		
of Vital	Physicien: The la this certificate ha ral director, page 2	To B	examiner? 1X Yes 2 ☐ No	Hospital: 1 🗆 In	patient 2	ER/Outpatier	nt 3 🗆 🗈	Othe Othe	er: 4 □ Nu	rsing Home	5 ☐ Resi	dence	Other	(Specify	SCE	NE
	E = E		27. Manner of Death  1XX atural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury	f	28c. Injury Work	at	28	d. Describe	how inj	ury occurred	1		
Sio	endin eath. or: Att	catle	2 Accident investigation				М		/es 2 🗆							
Division	or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	200. Flace	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, sti fy)	reet, facto	ry, office		28	f. Location ( City or To			or Rura	i Route N	umber,
			200 Codifies 4 Codificing 5	hyginian: T- 41 - 1		nuladas da-:	h ===	d at the at	a data :	d place se	d dua to the		a) and			
	Hos 24 ho Fun	Medical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the t miner: On the bas and manner	sis of examin	ation and/or in	vestigatio	n, in my of	oinion, dea	th occurred	at the time,	date a	s) and manr nd place, an	ner as si	the caus	e(s)
	To the Hospita within 24 hours To the Funerel completely filled	Me	29b. Signature and title of certifier	14			2	9c. License					ate signed (			
	7550		Mounte L.	8 (No. 11	(NI)			O C	ΜE			DE	CEMBE	K 18	, 200	<i>)</i> 4
	10/0		30. Name and address of person who		of death (Ite	m 23a) (Type,	Print)									04.004
	ME		MARGARITA KOREI				11	1 PE	IN ST	REET,	BALTI	MOR	E, MAI	KYLA	ND,	21201
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature										

DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Maryland	I / Depa	rtment of l	Health and	R	eg. 160. UU4	42470
	Physic /Medi Examin Funeral Director	cal	5. Social Security Number 6. Se	Tera street and number, eneral Hospital	st birthday) Yrs.	4b. City, Town, of a mb r	or Location of De	rs. 8. Date of Birth	Day Year  3 S S S S S S S S S S S S S S S S S S	3. Time of Death  A S 4/ M  A S 5/ M
21215-0036 KKV	be filed within 72 hours after death with the Maryland stal Hygiene. Ed other then "neturel", or Itame 23s or 28s-f show event, the Modisal Exactiver must be rectified at	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10c. Street and Number  4079 Ocean Gateway  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's Edicated Grace  (Specify only highest grace  Elementary/Secondary (0-12)	Linkw  12. Was Decedent Ever in U.S.  Ammed Forces? 195.  1 Xyes 2 No If Yes, Give 196.  year or Dates:	3 113. W 16a. Decede (Give k life. D	10f. Zip Code 2183	dispanic Origin? an, Mexican, Pue Specify: pation during most of wid)	(Specify Yes or No- erto Rican, etc.)	Og. Citizen of What C  USA  14. Race - Am Black, Whi Specify:  16b. Kind of Business  Construct:	erican Indian, te, etc. White
Baltimore, Maryland 21	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other traumatic event, ITeM ODGs.	To Be Co	11 17. Father's Name (First, Middle, Last) William John Era, 19a. Informant's Name/Relationship (T) Barbara Hughes Era 20a. Method of Disposition 1 \( \text{X} \) Burial 2 \( \text{Cremation} \) 3 \( \text{F} \) 14 \( \text{Donation} \) 5 \( \text{Other} \) (Specify)	A/Wife Removal from State Our	19b. Mailing 4079 ( ce of Disposi netery, crema Lady G	Address (Street Ocean Ga tion (Name of atory or other plac ood Coun	18. Mother's N Louise and Number or I teway, 1 ce) 12/2	Linkwood, Date 29/2004 S	Maiden Sumame)  City or Town, State, Maryland  Coc. Location - City or	Zip Code) 21835 Town, State
	Physician /Medical Examiner	Examiner	23a Party. Enter the disease, or composed, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to attended a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death.	Do not enter	6 Main S	treet, l		Market, MD	21631  Approximate Interval Between Onset and Death
ords, P.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions con	d	éath 3⊟E th 5⊟6	ctopic pregnancy Other (specify) Jerlying cause giv		1 ☐ Ye	23d. Date of del Month	Day Year of the cause of death? obably 4 Onknown
Division of Vital Record	ending Phyeicien: The eath. or: After this certificate h he funeral director, page	Certification; To Be Completed	27. Manuer of Death Natural 5 Pending investigation 3 Suicide 6 Could not be		NOutpatient  8b. Time of Injury  e, farm, stree		er: 4 🗆 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	prior to death?	cify)
NO.	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	Medical Certif	29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who co	building, etc. (Specify) sician: To the best of my knowlener: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the tir stigation, in my o	pinion, death occ	City or Town	, State) use(s) and manner as	stated. to the cause(s)
7	Sta Registr		Michelle F. Parson DEC 2 8 2004				on Stree	t, Easton	, MD 21601	

State of Maryland / Department of Health and Mental Hygiene

					,	Certifica	ate of	Death		F	Reg. No.	UH	424/1
			1. Decedent's Name (First, Middle, Last	)						2. Dete of Dee		Year	3. Time of Death
	Physici /Medio		Susan Elizabetl	h Ebaugh						Decembe	r 22, 2	2004	12:45 pm
	Examir		4e Fecility Neme (If not institution, give					4b. City, Tov	wn, or Loc	ation of Death	4c. County	of Death	_
			Westminster Nursi				ter der 1 Year	West				arro	
Н	Funeral		5. Social Security Number 6. Se	TM 4FF	In yrs. last bir	Yrs. Month			Min.	8. Date of Birth (Month, Day	, Year)		place (State or Foreign ntry)
	Director		212-01-8662 Usuel Residence of Decedent		L02				L	July 24	, 1902	Mar	yland
	/land		10a. State 10b. County	11	0c. City, Tow	n or Location							10d. Inside City Limits
	Man H	ō	Maryland Carroll		Mestr	ninster							1 ☐ Yes 2 No
	h the 28 m	<u>5</u>	10e. Street end Number		11000		Zip Code				log. Citizen of	What Cou	ntry?
	th will	a	1234 Washington 1	Rd.			21:	157			USA		
	r daa	Funeral Director	11. Merital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Was De If Yes, s	cedent of pecify Cul	Hispanic Orig ben, Mexican,	in? (Spec	cify Yes or No- tican, etc.)		ce - Ameri	can Indian, etc.
2	within 72 hours eftar death with the Maryland ana . than 'ratural', or items 23a or 28a-f ehow the Madical Examiner must be incitied at	by F.	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1□ Yes	2 <b>№</b> No	Specify:			Specif		
15-0020	ural L	9	3 Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	160	Decedent's U	cual Occu	ination			16b. Kind of B		ite
Ÿ	In 72	Completed	(Specify only highest grad	e completed)	104.	(Give kind of life. DO NO?	work done	durina most	of workin	g	100. Killd Ol B	usiiilessviii	laustry
7.17		E	Elementary/Secondary (0-12)	College (1-4or 5+)	F	actory	Worl	<			L. Gre	if S	-wina
D	be filad tal Hygi d other event, the	Be C	17. Father's Neme (First, Middle, Last)					-	r's Name	(First, Middle,	Maiden Surnar		52.5
<u></u>	D # 2 7	<u>0</u>	Daniel E. Essich	ς				Ne	ellie	. Kaye 1	Miller		
Mary	shou end M is mar		19a. Informant's Name/Relationship (T)	vpe, Print)	19b	. Mailing Addr	ess (Stree	at and Number	r or Rural	Route Number	r, City or Town,	State, Zip	Code)
Σ	end 2 laalth e m 27 is		Audrey Velnoskey	Niece	_20	1 St.	Mark	Way Ar	ot. 3	09 West	minste	r, M	21158
o e			20a. Method of Disposition  15€8urial 2 □ Cremation 3 □ F		20b. Place of cemeter	Disposition (f y, crematory o	vame of or other pla	ace)		Date	20c. Location -	· City or To	own, State
Ē	Pag mant ant: I		4 ☐ Donation 5 ☐ Other (Specify)		Haughs	Cemet				27/04	Ladie	sbur	, MD
Saitimor	parmit. Pagas 1 Department of H Important: If ite any Injury or ot page.		21. Signature of Funeral Service Licens	90		22. Name Prit	and Addr	ess of Facility ineral	Home	and Cl	napel,	PA	
	Q D = € Q		John K AS	0		412 W	ashir	ngton F	Rd. W	estmins	ster, M		1157
			23a. Part1. Enter the diseese, or compl shock, or heart failure. List only or	ications that caused the ne cause on each line.	e death. Do r	not enter the m	ode of dy	ing, such as o	cardiac or	respiratory arr	est,	1	Approximate Interval Between
7	Physician		Land distance (Final	11	- 0	-	11		,	n		1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	arten	rsch	riles	10	iscul	lend	ssens			254
		ē	3	arten	e to (or as a	consequence	of):					1	16211
	uted d ensit	Examiner			e to (or as a		3						102 grs
o o	certificeta be executed ding physician and use as the burial-trensit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injury that injury that injury that injury that injury that injury that injury that injury that injury the cause (Disease or injury that injury that injury the cause of the cause	00	0 10 (0. 00 0	, o. 1.00 quo 1.00 q						1	•
09/90	na bu	edical	Cause (Disease or injury that initieted events resulting in death) Last	Due	e to (or as a o	onsequence o	f):						
8	E 0 0	Med	resolving in death) Last									1	
o n	sath certifice attanding ph d for usa as t			J									
5		Physician/	Part II. Other significant conditions con	ntributing to death but n	ot resulting in	the underlying	g cause gi	iven in Part I.		23b. Did to	bacco use co	ntribute te	o the cause of death?
7.	hat the ad by detection									1 □ Y	es 2 2 No	3 Pro	bably 4 Unknown
g,	raquires that the ean signed by th hould ba detecha	d by								24a. Was a	n autonsv	24b. W	ere autopsy findings
	raqu bean shoul	Completed								perform	ned?	av co	ailable prior to impletion of cause
ě	hes b	E								47.74			death?
0	n: The ficete		25. Was case referred to medical					26 Place	of Dooth	Charle ante an	-,	1	☐Yes 2☐No
>	sicia s cart	o Be	avaminer?	lospital:	2 🗆 ER/Ou	tpatient 3	DOA Ot	her:	-	<i>(Check only on</i> e 5 □ Reside	ence 6 □Oth	er (Snecil	(v)
5	arthis aral c	Ë	27. Manner of Deeth	28e. Date of Injury (Month, Day Ye		ime of	28c. Iniu				w injury occur		,,
VISION	Attending or death.  ector: Aftar by the funa	윭	1 Natural 5 Pending 2 Accident investigation	(Monat, Day 7	041)	М		Yes 2□N	lo				
<u> </u>	er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (5	- At home, fa Specify)	rm, street, fact	ory, office		28	If. Location (St City or Town		er or Rura	I Route Number,
5	Italo Insetti Iladir												
	To the Hospital or Attending Physician: The lew within 24 bours effer death.  To the Funeral Director: Aftar this cartificate hes completely filled in by the funaral diractor, page 2.	edical	29a. Certifier 1 Certifying Physical Check only 2 decical Examin	sician: To the best of m	emination end	, death occurre Vor investigati	ed at the ti on, in my	ime, date and opinion, death	place, an occurred	d due to the ca d at the time, da	use(s) and ma ate and place,	inner as s and due to	tated. o the cause(s)
	ithin ithin ithe	Med	29b. Signature and title of certifier	and manner stated	1.	2	9c. Licen	se number		2	9d. Date signe	d (Month.	Day, Year)
	8484	- 1	. //	mid St.	the 2				>			-/-	
	MZL	-	30. Name and address of person who or	impleted cause of death	h (Item 23e) /	Type, Print)	0	> 445	2		42	1/24	DOF
	. 2	1	30. Name and address of person who co	Alokan	688	Pro le	R	ad 1	Ves	Amin	stor	m	021157
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrer's	Signature	,		/		· · · · · ·	/	,	
	Bogietr	7.5	11611.7.3	/ H BVI - FOO	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / De Ragistrar		t of Health e <i>of Deati</i>			ene . R. A. A. I.	10170
Г	Dhysisi	an.	Decedent's Name (First, Middle, Last)				Date of Death	C U U Y	3. Time of Death
	Physici /Medio		Alfred H. Fortune Jr.				beembe	Pay 23, 200	4 11:30PM
*	Examin	er	4a. Facility Name (If not institution, give street and number)		Town, or Location	n of Death		4c. County of Dea	
-			Doctor's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Lanh		er 24 Hrs. 8	Data of Birth	Prince G	
	Funeral Director		5.77-62-2822 1 M 2 □ F 57	Months	Days Hours	Min.	Date of Birth (Month, Day, Y	(ear) 9. Bit	rthplace (State or Foreign ountry)
	ס		Usual Residence of Decedent				march 10	5,194/ Wa	shington, DC
	nylan show	_	10a. State 10b. County 10c. City, Town o						10d. Inside City Limits
	8e-fs	cto	MD Prince Georges Riverda	Le					1 ☑ Yes 2 ☐ No
	with th	Director	10e. Street and Number	10f. Zip (			10g	. Citizen of What C	ountry?
	eath v	erai	5706 64th St.  11. Marital Status  12. Was Decedent Ever in U.S.	207		211212		USA	
	iter de ritem iner	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No	If Yes, speci	ent of Hispanic C ify Cuban, Mexic	Origin? (Specif an, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, Whi	
98	ursal	by I	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2	No Specif	fy:		Specify: B1	ack
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show re Mcdical Exeminer must be notified at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual	Occupation		16	b. Kind of Business	
2	ithin Je.	nple	Elementary/Secondary (0-12) College (1-4or 5+)		k done during mo e retired)				
2	led w lygier lyer th			mputer	Program			Gov't	
and	l be fi ntal H ed ot	Be	17. Father's Name (First, Middle, Last)				irst, Middle, Ma		
$\frac{3}{2}$	hould d Me mark matic	ို	Alfred H. Fortune Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. M	ailing Address			lexande	Ľ ity or Town, State, .	T 0 11
	nd 2 s Ith an 127 is 17au							VA 22310	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or othar traumatic evant, the Medical Examinating must be neithed at once.		20a. Method of Disposition 20b. Place of Di			Date		c. Location - City or	
Ë	Pages nent of I ant: If its ary or o		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Fort Li		1	Dog 30	2004 B	rentwood,	MD
Baltimore,	mit. partm ports ports y inju		21. Signature of Funeral Service Licensee	22. Name and	Address of Faci	ility.Iohns	on & .Ie	nkins Fun	eral Home
<u> </u>	89 1 8 8		Delaa Gent	716 Ker	nnedv St	. NW W	ashingt	on. DC 20	
			23a. Part1. Enter the disease, or complications that a used the stath. Do not shock, or heart failure. List on the cause on each line.	enter the mode	of dying, such a	s cardiac or re	spiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition INTRA CRAP		BIE				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):						
	LXdiiiiici	_	Sequentially list conditions, fany, leading to immediate	C C.	ANCE	R			
	ted nsit	nine	cause Enter Underlying	LURE					
,	execunand nand ial-tra	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	ZUKC					
68760	death certificate be executed e attending physician and id for use as the burial-transit	edical	d						
	ntifica ng ph as th		IF SCHALE						
Box	leath certi attending I for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pre	gnancy			23d. Date of dei	,
0		Physician/M		5 🗌 Other (spec				Month	Day Year
٦	hat th od by detacl	F.	Part II. Other significant conditions contributing to death but not resulting in the		una nivez in Dest		000 Did take		M
Vital Records,	The law requires that the steep seem signed by the base been signed by the bage 2 should be detache	d by	. arm. outsi organisan continuing to death but not resulting in the	underlying cat	use given in Pari	11.			o the cause of death?
Ö	w require been signature	Completed				13			
He	sician: The law certificate has l irector, page 2 s	dm					24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of
Ø		e Co	25. Was case referred to medical				1 ☐ Yes 2		2 🗆 No
	Physician: r this certific ral director,	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpat	ient 3 004			heck only one)	e 6 Other (Spec	-14.1
0	g Physer thi		27. Manner of Death 28a. Date of Injury 28b. Time		c. Injury at Work?		Describe how i		ciry)
0	tending Fasth. tor: After the funer	atio	2 Accident investigation	M	1 Yes 2	□No			
Division of	al or Attending F s after death. Il Diractor: After id in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory,	office	28f.	Location (Stree City or Town, S	t and Number or Ru tate)	ıral Route Number,
	urs af								
	e Hospital 24 hours a e Funaral I etely filled	edical	29a. Certifier Check only onel Medical Examiner: On the basis of examination and/or	ath occurred at investigation, in	t the time, date a n my opinion, de	and place, and ath occurred a	due to the caus t the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospital within 24 hours a To the Funaral completely filled	Mec	one) and manner stated.  29b. Signature and title of certifier,		License number			Date signed (Month	
	7378		M. s. show he luga		>396	00	1	7/94	104
	(0)		30. Name and address of person who completed cause of death (Item 23a) (Typ		210			-1271	
			SASHIBHAR MOVVA H.D. 723:		ANDVILL	PARICE D.	AY GIE	ELUBELT A	10 20 170
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	Registra	11	DEC 2 9 2004 Kee						

DHMH 17 Rev 1/2001

	NI FORD		1 - State of Maryland / Department / Department / Department / Department / Department / Departm	artment of Health and M rtificate of Death		giene Reg. No. 004	42473
	Physic /Medi		Decedent's Name (First, Middle, Last)     ANTHONY S. FORD II		2. Date of De	23, Day 2004 Yeer	3. Time of Death 0350 A M
*	Examir		4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER	4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GE	
	Funeral Director		5. Social Security Number  579-13-8891  Usual Residence of Decedent  6. Sex 1 Sex 2 F 7. Age (In yrs. last birthday) 28 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birt (Month, Da JULY 2,	y, Year) Cou	place (State or Foreign ntry) INGTON, DC
	death with the Maryland ms 23a or 28a-f show LTUST be notified at	ctor	10a. State 10b. County 10c. City, Town or Lot MARYLAND PRINCE GEORGE SPRINGDAL				10d. Inside City Limits 1   Yes 2  No
	ath with th 23a or 28 ust be no	ai Director	10e. Street and Number 9219 UTICA PLACE	10f. Zip Code 20774	1	10g. Citizen of What Cou JNITED STATE	,
920	ours after al', or Ita Examire	by Funeral		Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto			can Indian, etc.
21215-0036	s 1 and 2 should be filed within 72 hours f Haith and Mental Hygiene, Itam 27 Is marked other than "natural, other traumatic event, Ita Marical Ex	Completed	(Specify only highest grade completed) (Give life. Sementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) OCK CLERK		16b. Kind of Business/In	,
73	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) ANTHONY S. FORD, SR.	18. Mother's Name LINDA FR	(First, Middle,		STORE
	1 and 2 should be Health and Mental Im 27 is marked o ther traumatic eva			UTICA PLACE, SPRI	NGDALE,	MARYLAND :	20774
Baltimore,	8 = 5		1 Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Cemetery, crem FORT LING	COLN CEMETERY 12/3	0/04	BRENTWOOD, 1	
Bal	permit. Pa Departmen Important: any injury	ti i	1 1/1/ (1. Sarry 1/1/08) 155	LARME AND Address of Facility LEXANDER S. POPE F 538 MARLBORO PIKE/	FORESTV	ILLE, MD 20	0747
	Physician /Medical		23a. Part . Efter the disease or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	er the mode of dying such as cardiac o	r respiratory ari		Approximate Interval Between Onset and Death
8760,	Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
Records, P	w requires that been signed b should be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did to	bacco use contribute to the	
Vital Reco		e Completed	25. Was case referred to medical		0	sy prior to cor med? daath? 2□ No Yes	osy findings available npletion of cause of 2 No
of	ding Ph J. After th funeral	Certification; To Bo	was day referred to medical analysis and the special and the special analysis and the special an	28c. Injury at Work? M 1 ☐ Yes 2	ne 5 Reside 18d. Describe ho	ence 6 Other (Specify ow injury occurred Nach Co- treet and Number or Rura,	ecclant
J	To the Hospital or Attant within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  Check only one)  (Check only one)	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the cand at the time, d	ate and place, and due to	the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	29c. License number O.C.M.E	2	9d. Date signed (Month, I DEC. 23, 200	Day, Year)
R	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type, I	rint) N STREET, BALTIMOR	E,MARYL	AND 21201	
	Sta Registr	-	31. Date filed (Month, Day, Year)  DEC 2 9 2004  22. Registrar's Signature	e e			

			1 - For State Registrar	State of Man	/land / D	epartme	nt of Hea	Ith and M	lental Hyg	iene 004	42474
Г	Physicia	an	1. Decedent's Name (First, Middle, L	,					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic		VALORIE  4a. Facility Name (If not institution, g		FORD	4b. Cit	y, Town, or Loc	ation of Death	DECEMBE	R 26 2004 4c. County of Deat	22:45P M
	Examin	er	PRINCE GEORGE'S		OSPITAI		CHEVE			PRINCE GE	
	Funeral		Social Security Number 6.	Sex 7. Age (I	n yrs. last birti	hday) If Und	er 1 Year If U	Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day		hplace (State or Foreign untry)
	Director		214-80-5039  Usual Residence of Decedent  10a. State 10b. County	1□M 2\ F 44	Oc. City, Town	rrs.			October	6 1960 MAE	YLAND
	ath with the Marylan 23e or 28e-f show	ō									10d. Inside City Limits 1X Yes 2 □ No
	28a-	Director	MD PRINCE  10e. Street and Number	GEORGE 'S	BLADE	NSBURG 10f. 2	ip Code		1	0g. Citizen of What Co	
	h with		4105 55th AVENU	E		2	20710			U.S.A.	
	ams a	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.			nic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
20	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 □ Yes		pecify:	1110411, 0101)	0	
3	72 hours after dea "natural", or itams	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a		ual Occupation	,	200	16b. Kind of Business/	ACK
215-0036	within 72 hours after death with tha Maryland iene. rthan "natural", or Itams 23a or 28a-f show the Madical Examinar mat be mullised at	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of w life. DO NOT	rork done durini	g most of work	ing	160. Kilid di Business/	ridustry
7	giene giene er tha	Com	11th	College (1-401 5+)	D	OMESTIC	3			PRIVATE	
2	be filad tal Hygid d other event, I	Be (	17. Father's Name (First, Middle, Las	•			18.	Mother's Name	e (First, Middle, i	Maiden Sumame)	
yland	Ment Ment Marka Marka	2		LMES					R. FORD		
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship DEWAYNE GREENWEL							, City or Town, State, 2 Maryland	<sup>(ip Code)</sup>
	it. Pages 1 and 2 should be urtment of Health and Ments urtant: If item 27 Is marked njury or other traumatic e		20a. Method of Disposition			Disposition (N.				20c. Location - City or	
Baitimore,	ages ent of tr: If it		1 ☑ Burial 2 ☐ Cremation 3  3 ☐ Cremation 5 ☐ Other (Spec	THE PROPERTY OF THE PARTY OF TH	_	, crematory or ection		1/3/0			
	parmit. Pag Department Important: any injury once.		21. Signature of Funeral Service Lic		Result	_				Clinton,Ma ins Funeral	
ñ	Par E B		16 6 h			7474	Landove	r Koad	Landove	r, Marylan	d 20785
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications Fal caus of the ly one cause on each line.  SEIZURE	death. Do n	ot enter the mo	ode of dying, su	uch as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence o	ıf):					
	Lamine	_	Sequentially list conditions,	b. Asthma A		0.		<u>.</u>			
	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 25 a c	orisequerice o						
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence o	f):					
8/60,	ite be lysicia ne bur	cal		d							
٥	ortifica ing ph as th	Med	IF FEMALE:								
XO2	death certificate e attending phys d for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 □Ectopic				23d. Date of del	very Day Year
	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death	5 Other (	specify)				,
λ, J	law requires that the as baen signad by th 2 should be detache	by Ph	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying	cause given in	Part I.	23e. Did tot	pacco use contribute to	the cause of death?
	w requires baen sig should be								1 □ Ye	es 2⊠No 3∏Pr	obably 4 Unknown
ecord	law re as bac 2 sho	Completed							24a. Was a	n 24b. Were au	topsy findings available ompletion of cause of
r	sician: The law certificate has l irector, page 2 s	Com							perform	ned? death?	
VItal	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			0.1		h (Check only on		
0	Phy this ral d	. To	1 ☐ Yes 2 🔀 No  27. Manner of Death	1 ☐ Inpatient	21 ER/Out 28b. T	patient 3 🗆 E				ence 6 Other (Spec	eify)
	iding Fig.	tlon	1 Natural 5 Pending 2 Accident investigat	(Month, Day Ye		jury M	28c. Injury at Work? 1 ☐ Yes		280. Describe no	ow injury occurred	
UIVISION	tal or Attending s after death. al Director: After ed in by the funer	Certification	3 Suicide 6 Could not 4 Homicide determine	be Goo Bloom of Injury	- At home, far Specify)	m, street, facto	ory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
_	Hospi 4 hour Funer ely fill	Medical Co	(Check only 2 Medical Ex	Physician: To the best of ra aminer: On the basis of ex	amination and	death occurre	d at the time, d	ate and place,	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	one) 29b. Signature and title of certifier	and manner stated	L		9c. License nur			9d. Date signed (Monti	
	- 3 + 8		Jan da (	It have	mè		Dai	428	-	Dec 27,	1
1	(2)		30. Name and address of person wh	o completed cause of deat	h (Item 23a) (	Type, Print)	001	100		vec ary	W507
1			Linda D. Green	M.D. 3001 I	Hospita		e Cheve	rly, Ma	aryland	20785	
6	Sta Registr		31. Date filed (Month, Day, Year)  DEC 2 9 200	2. Registrar's	Signature-	really					

DHMH 17 Rev 1/2001

	4	1 - For State Registra AMEND ITEM				artment of				6	1001	, 4	2475
		Decedent's Name (First, Middle, Last		KPH GO	10 2703	y US UIF	Dout		2. Date of De				Time of Death
Physicia /Medic		EMMANUEL AD	RIEN	FOREST	TIER			I	DECEMB				1:00A M
Examin	er	4a. Facility Name (If not institution, give		,		4b. City, Town					. County of [		
		National Institut  5. Social Security Number 6. Se		Health 7. Age (In yrs.	last birthday)	Build If Under 1 Ye	ethesc ar   if Unde	la er 24 Hrs.	8. Date of Bir	rth	lontgo		(State or Foreign
Funeral Director			3M 2□F	51	Yrs.	Months Day	s Hours	Min.	May 12	av. Year)	)	Country) Franc	
pu .		Usual Residence of Decedent  10a. State 10b. County		100 Ci	ty, Town or Lo	cation							nside City Limits
Aaryla f sho	ō	,		100. 01	ty, rown or Lo	Bethes	da					ŀ	☐Yes 2XNo
r 28a-	Director	Maryland   Montgome	ГУ			10f. Zip Code				10g. Ci	tizen of Wha	t Country?	
th with	alD	7405 Honesty Way					20817			F	rance		
er dea tems	Funeral	11. Marital Status	Armed Fo	edent Ever in U prces?	J.S. 13. \	Was Decedent of f Yes, specify C	of Hispanic C uban, Mexic	origin? (Spean, Puerto	ecity Yes or No Rican, etc.)	D-	14. Race - A Black, V	American In Vhite, etc.	dian,
II, or I	by F	1 ☐ Never Married 2 ☑ Married 2 ☑ Married 2 ☑ Midowed 4 ☐ Divorced	1 ∐Yes If Yes, Giv Year or D	/ <del>0</del>		1□Yes 2⊠N	lo Specif	y:			Specify:	Whit	e
ING 21215-UU36  be filed within 72 hours after death with the Maryland tial Hygiene.  Ind other than "natural", or Items 23a or 28a-f show evant, the Medical Examiner must be notified at	ted	15. Decedent's Edu (Specify only highest grad	ication			ient's Usual Occ kind of work do		net of worki	ina.	16b. K	and of Busin		
Athin and and and and and and and and and an	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life. I	DO NOT use ret	ired)	JST OF WORK	,,,g				
filed v Hygie ther ti nt, th	S	17. Father's Name (First, Middle, Last)	5+		р:	irector	18. Mot	her's Name	(First, Middle		World	Bank	
	To Be	Claude Eugene For	estier						Thier		ouao,		
Aarylan 2 should be 2 should be 1 and Mental 1 is markad c		19a. Informant's Name/Relationship (T)			19b. Mailin	g Address (Stre					or Town, Sta	te, Zip Code	e)
and 2 ealth in 27 i		Helene Forestier/	Wife	1-21	7405	Honest	y Way,						
Baltimore, Maryland bernit. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: If Itam 27 is marked oth, any injury gother traumatic event ans.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		State		sition (Name of natory or other p	I		5,2005		ocation - City	177	
Itir it. Pa it. Pa itimer infunt		<ul><li>4 □ Donation 5 □ Other (Specify,</li><li>21. Signature of Funeral Service Licens</li></ul>		Cin		de Sill			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Sil.	lars,		e -Chevy
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: if Itam 27 is marked any injury goother traumatic events.		Rost		M00	Ro Ro	bert A. 7 Wiscon	Pumph	rey l	Funeral	Hon	ne/ Ci	ASE.	Inc
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that one cause on e	aused the deat	th. Do not ent	er the mode of c	lying, such a	is cardiac c	or respiratory a	rrest,	UZ.UU_1	Appr	roximate val Between
Physician		Immediate Cause (Final disease or condition		ER FA								11	et and Death lays
/Medical Examiner		resulting in death)		(or as a consec									1 M. Sec. 11 51
	ě	5 according to immediate		MPHOMA (or as a consec								, z y	pars
outed od ransit	Examln	Cause (Disease or injury that initiated events	c										
18 760, cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	(or as a consec	quence of):								
58760 icate be e physician s the buria	dlcal		d									-	
BOX 6 death certifi e attending I	□/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		-				0	23d. Date of	delivery	
. 0 00	by Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		ointh 2 □ Feta nant at time of c		Ectopic pregnal Other (specify)					Month	Day	Year
P.O.	Phy	9 Unknown			ultica ia tha u	-1			220 Did t	abassa.	uaa aaatabut	to to the sev	use of death?
ecords, P.O. law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions co	ntributing to di	eath but not res	saking in the ar	idenying cause	given in Pan				□No 3□		
VItal RECORGS, sician: The law requires t certificate has been signe rector, page 2 should be o	lete		_						24a. Was	an	24b. Were	autopsy fir	ndings available
The lav	Completed								autor		prior	to complete h?	on of cause of
VItal I	BeC	25. Was case referred to medical examiner?					26. Pla	ce of Death	(Check only o			100 2421	
Of V Physic rthis ce	٩	1 ☐ Yes 2 🗹 No			ER/Outpatien	1 3 00 N			me 5 Resid			Specify)	
On On On On On On On On On On On On On O	tlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	of Injury th, Day Year)	28b. Time of Injury	V	luryat Vork? □Yes 2[		28d. Describe I	now inju	гу оссиггеа		
DIVISION  or Attanding after death. Diractor: Afte	ifica	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At h	ome, farm, str	et, factory, offic			28f. Location (S			r Rural Roul	te Number,
Listed or rs after all Dir.	Certification:	4   Homiciae	Dullai	ing, etc. (Specia					City of 10	WII, State	·/ 		
DIVISION Of VITAI To tha Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certifica completely filled in by the funeral director.	edical	29a. Certifier Certifying Phy (Check only 2 Medical Exam	i <b>ner</b> : On the b	asis of examina	owledge, death ation and/or inv	occurred at the restigation, in m	time, date a y opinion, de	and place, a eath occurre	and due to the ed at the time,	cause(s) date and	and manne place, and	r as stated. due to the c	ause(s)
o tha ithin 2 o tha omplei	Med	one)  29b. Signature and title of certifier	and man	ner stated.		29c. Lice	nse number	,		29d. Da	te signed (M	onth, Day,	Year)
			1			23	3755			10	1/23	104	
70		30. Name and address of person who c	mpleted caus	se of death (Iter	m 23a) (Type,					1 -	100	1	
		ANTOINETPE	WILLI			ITER DE	RIVE,	BETI	HESDA,	MD	208	92	
Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa	g g	Sport	21						

			1 - For Stete Registrar	State o	of Maryland / [	Departme <i>Certifica</i>				giene ()	04	424	76
			1. Decedent's Name (First, Middl	e, Last)					2. Date of De	ath		3. Time o	f Death
н	Physici		James Simpson	Foley					Month Decemi	ber 22,	Year 2004	8:40	ам
	/Medic Examir		4a. Facility Name (If not institution	n, give street and nu	mber)	4b. City	, Town, or	Location of D		· · · · ·	ty of Death	1	
	LXAIIII	ICI	Washington Ad			Tr.	koma	Park		Mon	tgome	rv	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bir	thday) If Unde	r 1 Year	If Under 24		th	9. Birthp	olace (State	or Foreign
н	Director		579-18-4015	<b>1</b> ∕⊡M 2□F	80	Yrs. Months	Days	Hours I	Min. (Month, Da April 2		Cour	ntry) shingt	
	D		Usual Residence of Decedent						110111	7, 152	1	JII III G C	0117 D
	ylan how		10a. State 10b. County		10c. City, Tow	n or Location					1	10d. Inside C	ity Limits
	Ma Hiller	tor	Maryland Monto	omerv	Silv	er Spri	na					1 Tes	<b>3</b> √□ No
	h the	Director	10e. Street and Number			10f. Z	p Code			10g. Citizen o	f What Cour	ntry?	
	th wit	aiD	403 Deerfield	Avenue			209	10	6		USA		
	dead dead	by Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. Was Dec	edent of His	spanic Origin	? (Specify Yes or No Querto Rican, etc.)		ace - Americ		
9	or He	F	1 ☐ Never Married 2 ☐ Marr			1 ☐ Yes		Specify:	derio riicari, etc.)				
93	irat',	d b	3 Widowed 4 Divorced	Year or E	oates: 1942-4!		2140	opecny.		Spec	whi	te 	
215-0036	within 72 hours after death with the Maryland one. than "naturat", or items 23a or 28e-f show the Madical Examinat must be notified at	Completed	15. Deceden (Specify only highe	it's Education st grade completed)		Decedent's Us (Give kind of w	ork done d	uring most of	f working	16b. Kind of	Business/In	dustry	
21	ithin Per	npl	Elementary/Secondary (0-12)	College (	1-4or 5+)	life. DO NOT	use retired,	) -					
CA	ygier ygier her th	Col	12			Owner					o Par	ts	
pu	be fill H d oth	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle,	, Maiden Sum	ame)		
yla	should be filed within 72 hours nd Mental Hygiene. i marked other than "natural", i umatic svent, the Medical Era	2	Hubert M. Fo	-					olet Louve				
Maryland	2 sho and Is ma		19a. Informant's Name/Relations	hip (Type, Print)	196	. Mailing Addres	s (Street a	nd Number o	or Rural Route Numb	er, City or Tow	n, State, Zip	Code)	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Eraminer must be notified at		Evelyn_Foley/	Wife				d Aven	ue, Silve				)
ore	if ite		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from	comoto	Disposition (Na ry, crematory or	ime of other place	De De	ecember 27	20c. Location	n - City or To	own, State	
<u>Ē</u>	Pag ment ent:		'4 □Donation 5 □ Other (S			ia Gard	ens Ce	emetery	2004	Arling	ton, V	/irgin	ia
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra once.	1	21. Signature of Funeral Service	Licensee		22. Name a	nd Addres	s of Facility	ns Funeral	Home	Inc		
<u>m</u>	89 2 2 9		Jilles Skikes						Lvd, W, Si			MD 2	0901
	Physician /Medical		23a. httl. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	caused the death. Do each line.	onia				rrest,	/	Approxima Interval Be Onset and	tween
38760,	icate be executed was physician and physician street in burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	<b>S</b> . Z	or as Insequence	Sepons Mossis	10/11	fus Fai	type /ure	Z		24	lays.
.O. Box 6	the death certil by the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live I	tcome of pregnancy birth 2  Fetal death nant at time of death lown	3 □Ectopic 5 □ Other (s					ate of deliver	-	Year
Records, P.	w requires that s been signed t should be deta	Completed by P	Part II. Other significant conditi	conscionation of the contributing to defermine the contributing to defermine the contribution of the contr	eath but not resulting in	the underlying	te ri	in in Part I.	23e. Did t	obacco use co Yes 2 No		he cause of do	
00	s bee	ojet			/				24a. Was		. Were auto	psy findings	available
Re	siclen: The law s certificate has t irector, page 2 s	E O								rmed?	death?	mpletion of o	ause of
Vital		O	25. Was case referred to medica	1	<del></del>			26 Place of	1 ☐ Yes Death (Check only of	2 XNo	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	21110	
5	Physiclen: this certificated director,	0 0	examiner? 1 ☐ Yes 2 XNo	Hospital:	npatient 2 ☐ ER/Ou	tpatient 3□ 0	OA Othe		ng Home 5 Resid		ther (Specifi	iv)	
o	Phys ar this aral di	F	27. Manner of Death	28a. Date	of Injury 28b.	Time of	28c. Injury	at	28d. Describe I			y/	
on	th. : After s funer	tio	1 Natural 5 Pendir 2 Accident investi	19	nth, Day Year)	njury M	Work 1 □ Y	:7 ′es 2 ∐ No					
Division	el or Attending s after death. Il Director: After d in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace	e of Injury · At home, faing, etc. (Specity)	rm, street, facto	ry, office		28f. Location ( City or Tox		nber or Rura	I Route Nun	nber,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	(Chek only 2 Medical	Examiner: On the band man	e best of my knowledge pasis of examination an oner stated.	e, death occurre d/or investigation	d at the tim	e, date and p inion, death	place, and due to the occurred at the time,	cause(s) and n date and place	nanner as si , and due to	tated. the cause(s	;)
	To T com	Σ	29b Signature and title of certific	7 1	00	25	c. License	-	-	29d. Date sign	ed (Month,	Day, Year)	
,	141		You t	. 12n	relli, 1	MJ	D	35	055	121	23/	104	
	1 1 1		30. Name and address of person	who completed cau	se of death (Item 23a)	(Type, Print)	0	,	ille Road	0	1/		
_			Vrose F	. Bonel	/i, M.),	8807	Co	Ksu,	ille 1400d	1,511	ver 5	oring	M.D.
	Sta		31. Date filed (Month, Day, Year, DEC 2 7	2004	Registrar's Signature	9 los	31/2/					209	10

			1- State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygien	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medio		Lutgarda Furtado		Dec. 26,	2004 Yeer 5:30 P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			Ft. Washington Hospital	Ft. Washington		Prince George's
	Funeral		5. Social Security Number 6.10 - 10 - 1151 6. Sex 1 □ M 2 ▼ F 68 7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 7. Age (In yrs. last birthday 8. Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		619-40-1451 The series of Decedent The series		05-13-193	6 Philippines
	land W		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Many ish	to	MD Charles Waldor	:		1 ☐ Yes <b>2</b> Y ☐ No
	ith the Marylar or 28a-f show	rec	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	3a o	O I	3002 Hosta Crt.	20603		U.S.A.
	deat ms 2	ner		Was Decedent of Hispanic Origin? (Spo If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
ဖွ	after or ite	Fu	1 Never Married 2 Married Armed Forces? 1 Yes 2 M No If Yes, Give	- 4	Hican, etc.)	Black, White, etc.
8	ural',	d b	3   Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 【X No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Mcdical Excinitivit is ust by trufflied at	Completed by Funeral Director	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry
121	withir sne.	m	Elementary/Secondary (0-12) College (1-4or 5+)			N-4-27
2	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	es Associate	(First, Middle, Maide	Retail
Maryland	2 should be filed withir and Mental Hygiene. is markad other than aumatic event, the M	o Be	Jose Antonio Barretto	Aida R		in Sumaney
2	Shoul nd Me mark	은		ng Address (Street and Number or Rura		or Town State Zin Code)
	and 2 ealth a n 27 is			Bayonet Place, Od		21113
re,	is 1 and of Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place)	Date 20c. I	Location - City or Town, State
Ë	Pages nent of h ant: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  `4 ☐ Donation \$ ☐ Other (Specify) Huntt Cr		-2004 Wal	dorf, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-f show any injury or other traumatic event, If a Wedfell Examinational Landillad at ADEs.			2. Name and Address of Facility Huntt Funeral Hom	-	
m	88 = 8		Vact 71. William	P.O. Box 156, Wal	dorf, MD	20604
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	naphologo	Inforce. They	Injerval Between Offset and Death
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 exopths?  1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the	Inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	uires sign ld be	d by	Lou Gerling disease		1 ☐ Yes 2	2 No 3 Probably 4 Unknown
00	w require been si should b	lete			24a. Was an	24b. Were autopsy findings available
Re	The lay	Completed			autopsy performed?	prior to completion of cause of death?
tal		e C	25. Was case referred to medical	26. Place of Death	1 □ Yes 2 ₩ N	o 1 Yes 2 No
≥	Physician: this certific ral director,	0 B	examiner?  1 Yes 2 No Hospital:  1 Hospital:	Other	ne 5 Residence	6 □Other (Specify)
		n: T	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how inju	
<u>ö</u>	Attending I r death. ector: After by the funer	atic	2 Accident investigation	M 1 Yes 2 No		
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number,
	ital or urs afte ral Dir lled in			4		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier  (Check only (Check only of the Description of the Desc	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause(s ed at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	thin 2 the orthe	Med	one) and manner stated.  29b. Signature, and title of certifier.	29c. License number	29d D	ate signed (Month, Day, Year)
ŧ	S 7 8 7	-	A. T. Alila La and Now			- 27 - 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type.	D46046	IK.	-XT. NO.
M	P 3		Dr. A. M. Alikhami, 11711 Livingsto		ton, MD 20	744
	Sta	te	31. Date filed (Month, Par Cear) 8 2004 32. Redistrar's Signature	1		
	Registr		DEO AD LOUT STATE S.	Good		

		1 - For State Registrar		d / Department of F Certificate of	lealth and Me	•	<sup>8</sup> nnl	42478
Physi /Med Exan	dical	Sandra Lynn Fra	ley	4h City Town o		Date of Death Month Da		
Funera	al	Memorial 5. Social Security Number 6. Se	Hospital	Eq.	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Oay, Year Aug 28 19	1a ( bo )	place (State or Foreign intry) yland
e Maryland la-f show	ctor	Usuel Residence of Decedent  10a. State  10b. County  Maryland  Carol		y, Town or Location		aug 20 17	JZ Hai	10d. Inside City Limits  1 Yes 2 □ No
th with the 23a or 26 ust be no	al Director		rtments	10f. Zip Code 21629	9		itizen of What Cou	intry?
filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or items 23a or 28a-f show ent, the Modical Exactine must be notified at	by Funeral	3 ☐ Widowed 4 X Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of F If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ameri Black, White Specify: W	
within 72 ho ene. than "natur he Modical	Completed	15. Decedent's Ed (Specify only highest grade   Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired disabled	nation during most of working d)	16b. F	(ind of Business/Ir	ndustry
m - 0 2	To Be Co	17. Father's Name (First, Middle, Last) Russell Harris				amper Har	n Sumame)	
and 2 should be file fealth and Mental Hy om 27 is marked oth ther traumatic event	Ï	19a. Informant's Name/Relationship (7  Ruth A. Harris/ n  20a. Method of Disposition	nother	19b. Mailing Address (Street  111 Whiteleys	sburg Road	Greensbor	o, MD 21	.639
permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 is marked any injury or other traumatic ev	oji	1 X Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify  21. Signature of Figure 1 Service Licen:	Gre	lace of Disposition (Name of ametery, crematory or other place ensboro Cemete 22. Name and Addre	ery   12/23/	04 Gree	ensboro,	Maryland
Dep Imp	ouce	23a. Part1. Enter the disease, or comp	lyc	Fleegle ar PO Box 160	ss of Facility nd Helfenbe ) Greensbor	in Funera	11 Home,	
Pnysicial /Medica Examine	al	Immediate Cause (Final disease or condition resulting in death)	a. Pneumoni  Due to (or as a consequence Cano	Lence of):	g,	sopratory arrost,		Approximate Interval Between Onset and Death Day S  Mon Hh S
death certificate be executed to attending physician and ad for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):				
aath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnancy			23d. Date of delive	ery Day Year
The law requires that the deate has been signed by the spage 2 should be detached	þ	Part II. Other significant conditions co	entributing to death but not resu	Ilting in the underlying cause give	en in Part I.	23e. Did tobacco		he cause of death?
2 2	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available mpletion of cause of
ng Phy fter this	ion: To Be	27. Manner of Death  1 Salatural 5 Pending		ER/Outpatient 3 DOA Othors 28b. Time of Injury World	y at 28d			y)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory, office	Yes 2 □ No 28f.	Location (Street ar City or Town, State	nd Number or Rura a)	ul Route Number,
he Hospi in 24 hour he Funer pletely fill	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsicien: To the best of my know iner: On the basis of examinati and manner stated.	wledge, death occurred at the tirr ion and/or investigation, in my op	ne, date and place, and pinion, death occurred a	due to the cause(s	and manner as s d place, and due to	tated. the cause(s)
To t with To t	×	29b. Signature and title of certifier	idyenathan		7749		te signed (Month, MBCR 2	Day, Year)
	itate	30. Name and address of person who con Dr. Lakshmi Vaidy 31. Date filed (Month, Day, Year)		S. Washington S	Street East	on, MD 21	601	
Regis		DEC 2 3 2		A hoost o				

Sandra

State of Maryland / Department of Health and Mental Hygien 1 - State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** ELIZA BETH /Medical 2004 ΑM Dec 9:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care The Pines Talbot Easton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign
Country) 1□M 2回F Months Hours -14-7605 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pagas 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-1 ehow any injury or other traumatic event, Its Madical Exprintment unit be notified at any injury or other traumatic event, Its Madical Exprintment unit be notified at 10d. Inside City Limits AROL 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 416HWA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HALLENGREN ILLSTROM HULDA ္က 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES F. FRETTERDISON HIGHWAY, FEDERALSBU 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign It re of Funeral Service Licenses 1000 SITSOUTH MAINSTREET FEDERALSBURG, MO 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular disease or condition resulting in death) /Medical **Examiner** Athero scherosis 42213 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ba detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 Tes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? ult cancer, underi 2 🗀 No 2 No 1 Yes 1 ∏ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 🗌 Yes **≥**SNo 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director; After t Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-2704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 508 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 2

Mildred Fretterd

		4	For State Registrar	State of N	aryland	/ Depa	artment <i>tificate</i>	of H	ealth a Death	nd Mei	ntal Hygi	ene g. No.	004	42480
	Dhusisi		1. Decedent's Name (First, Middle,	Last)			-			2.	Date of Death Month		Year	3. Time of Death
	Physici /Medic		MARY FOG	3						De	ecember		, 2004	11:05 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, g						Location of	Death			County of Dea	
			FREDERICK MEI  5. Social Security Number 6		PITAL Age (In yrs. las	t hirthdau)	FRE If Under	DER.	ICK If Under 2	4 Hrs lo	Data of Birth		FREDER	
н	Funeral Director		007-26-2198	1 M 2 P F	102	Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day,		1 00	thplace (State or Foreign ountry)
	ъ		Usual Residence of Decedent							De	pt. 29	`ـــو	902 Mai	ine
	show	<u>.</u>	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	8a-f	Director	Maine Cumberl	and	Casc	0								1 ☐ Yes 2 ☐ No
	with the		10e. Street and Number				10f. Zip (				10	-	en of What Co	ountry?
	eath	eral	368 Roosevelt Tr	ail 12. Was Deceder	t Ever in U.S.	13. V		015	spanic Orig	in? (Snecif	v Yes or No-	USA	4. Race - Ame	erican Indian
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 Ia marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ite Medical Examinating the notified at	by Funeral	1 Never Married 2 Married  3 ☼ Widowed 4 Divorced	Armed Forces	? No		f Yes, speci I ☐ Yes 2		Specify:	Puerto Ric	y Yes or No- an, etc.)		Black, Whit	
5-0	72 ho	Completed	15. Decedent's (Specify only highest	Education			lent's Usual kind of work			of working	1	6b. Kin	d of Business	/Industry
7	vithin ne. han *	mpie	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. L	OO NOT use	e retired)	g					
2	filed v Hygie other t		9 17. Father's Name (First, Middle, La	st)		Н	omema		18 Mother	e Nama /E	irst, Middle, M		n Home	1
and	d be f antal h red of	o Be	Jesse	31)	Lewis				Mab					
Ž	2 should be and Mental I a marked o aumatic eve	P	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a			oute Number,	mba] City or		Zip Code)
Š	and 2 Balth ar n 27 la		Barbara Merrill/	Daughter							sco, M	-		
Jre,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition			e of Dispos	sition (Name	e of		Date			ation - City or	Town, State
Ē	Pages nent of I ant: If its ury or o'		1 Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe		0 1	-	Cemet	-		12/26/	2004	Harr	ison.	ME
alt	permit. Departir Imports any inju		21. Signature of Funeral Service Lic	ensee		22	. Name and	Address	s of Facility	Stau	ffer F	uner	alHome	PA
	205 20		- foculy	UL.							e, Fre		ck,MD	
			shock, or heart failure. List or	mplications that cause one cause on each	ed the death, line.	Do not ente	er the mode	of dying	, such as c	ardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
ä	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		ACRI		1	BL	FED	ING				2 DAYS
В	Examiner			Due to (or a	s a consequer	nce of):								
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequer	nce of):								
	d ansit	Examiner	Cause (Disease or injury that initiated events											
Ó	a exec an an irial-tr	Exa	resulting in death) Last	Due to (or a	s a consequer	nce of):								
8760,	cate be executed physician and the burial-transit	dicai		d.										
9	e as t	Med	IF FEMALE:									1		
Box	death certific e attending pl id for use as t	by Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3	Ectopic pre					23	<ul> <li>d. Date of del Month</li> </ul>	ivery Day Year
o.	0 0 0	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of deat	n o	Other (spe	спу)						
٣.	that the	y Ph	Part II. Other significant conditions	contributing to death	but not resulting	ng in the un	iderlying ca	use givei	n in Part I.		23e. Did toba	cco us	e contribute to	the cause of death?
rds,	luires tha n signed ald be det						_				1 ☐ Yes	2 💢	No 3∏Pr	obably 4 Unknown
CO	The law requires that the steep see signed by the sage 2 should be detached.	Completed									24a. Was an	Т	24b. Were au	itopsy findings available
Re	The lav	шо									autopsy perform 1 Ves 2	ed? X No	prior to death? 1 ☐ Yes	completion of cause of
Vital Record		Bec	25. Was case referred to medical examiner?						26. Place	of Death (C	heck only one	•		
× <	hysic his ce il dire	To	1 ☐ Yes 2 No	Hospital: 12 Inpa		VOutpatient	3 DOA	Other	r: 4 ☐ Nurs	sing Home	5 🗌 Resider	ce 6	□Other (Spe	cify)
n	ing P		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28 Pay Year)	3b. Time of Injury		lc. Injury Work			. Describe hov	injury	occurred	
Sio	ttendi death. stor: A	cat	2 Accident investigat 3 Suicide 6 Could not	he			M		es 2∐N		Laurtine (Ct.	-4	M	
Division of	ul or Attending Phy after death. I Director: Atter this d in by the funeral c	Certification:	4 Homicide determine	28e. Place of li building,	etc. (Specify)	e, rann, stre	et, ractory,	опісе		201.	City or Town,		Number or At	ıral Route Number,
	To the Hoapital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1X Certifying	Physicien: To the bes	at of my knowle	edge, death	occurred a	t the time	e, date and	place, and	due to the car	ise(s) a	nd manner as	stated.
	To the Hoapita within 24 hours To the Funeral completely filled	edical	(Check only 2 ☐ Medical Ex	eminer: On the basis and manners	of examination	and/or inv	estigation, i	in my opi	inion, death	occurred a	at the time, dat	e and p	lace, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier					License			29	d. Date	signed (Monti	h, Day, Year)
)			Kirkstel	HOSPI	TALL	ST	_ D	00	592	-83	Dr	ECE	M13 E	2 23 2004
	5		30. Name and address of person w	o completed cause of	death (Item 23	3a) (Type, I	Print)						1	23 2004 ND 21701
		_	Dr. Richard 31. Date filed (Month Pay Year)	Addo	30 0 trar's Signatur		+ 7-	th.	Stro	e+	Fred	eri	ck, n	70 21701
	Sta Registr		DEC 2 7	2004	Gera A	The A	back	0					/	

			1- State of I	Maryland / Depa	artment of F			iene .2.004	42481
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Geraldine  4a. Facility Name (If not institution, give street and number	ischer	4b. City, Town, o	r Location of Death	2. Date of Deat Month		3. Time of Death 5:05 PM
	Funeral Director		St. Catherine 's Nursing           5. Social Security Number         6. Sex         7.           235-50-8133         1 □ M 2 ☒ F         7.           Usual Residence of Decedent	Center Age (In yrs. last birthday) 69 Yrs.	Emmitsb If Under 1 Year Months Days	urg   If Under 24 Hrs.   Hours   Min.	8. Date of Birth (Month, Day, May 29,	Freder Year) 9. Bir 1935 Wes	rick thplace (State or Foreign ountry) st Virginia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent. The Medical Evant at must be notified at 2006.	To Be Completed by Funeral Director	10a. State   10b. County   Maryland   Frederick   10e. Street and Number   105 Orchard Drive   11. Marital Status   12. Was Deceder Armed Force   1   Yes   2   15. Decedent's Education   (Specify only highest grade completed)   12   17. Father's Name (First, Middle, Last)   Webb Carr   19a. Informant's Name/Relationship (Type, Print)   Beverly Nunemaker / Daught   20a. Method of Disposition   1	se?  XNo se:  16a. Decer (Give life. If 19b. Mailir 13230  20b. Place of Dispo commetary, crar Lewistown  122 10	Was Decedent of H If Yes, specify Cube 1 Yes 2 No  dent's Usual Occup kind of work done DO NOT use retired Actory Word  and Address (Street  Catoctin  stition (Name of malory or other plac n Cemeter Name and Address 4 E. Mair	lispanic Origin? (Spean, Mexican, Puerto Specify:  ation during most of working)  rker  18. Mother's Name Millie and Number or Rura Furnace  Furnace  (Se) Decemy 24, sss of Facility Stanta	ng  (First, Middle, Margare Margare Moute Number, Road Th Date 2004 auffer F Thurmon	Business Faiden Sumame) t Miller City or Town, State. nurmont, M. 20c. Location City or Lewistown, uneral Hom t, Marylan	Ates  arican Indian. te, etc.  White  Vindustry  Form Company  Zip Code)  aryland 2178  Town, State  Maryland tes, P.A. dd 21788
8760,	And the burial-transit the buria	dical Examiner	23a. Part1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or d	as a consequence of):  as a consequence of):  as a consequence of):	Faile Pne Inforc	umonic tro			Approximate Interval Between Onset and Death 2 Yours  i Wk
O. Box 6	that the death certifics ed by the attending pt detached for use as ti	Physiclan/Medical		2 ☐ Fetal death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
of Vital Records, P.	The law requires ate has been sign page 2 should be	e Completed by	Part II Other significant conditions contributing to death  Asttrus (OP)  Attlus alluste  Clob Lastona  25. Was case referred to medical	Condition in the un	scular	Ander 26, Place of Death	1  Ye  24a. Was ar autopsy perform 1  Yes 2	24b. Were at prior to death? No 1 \( \text{Yes} \)	robably 4 Unknown utopsy findings available completion of cause of
Division of Vi	ding Phys n. After this funeral dir	Certification; To B	examiner?  1 Yes 2 No  27. Manner of De th  1 Nantural 5 Pending investigation 3 Suicide 6 Could not be determined.		28c. Injun Worl M 1	er: 4 Nursing Hor y at (2 k? Yes 2 \( \text{No}\)	ne 5 Resider 28d. Describe ho	nce 6 Other (Spewinjury occurred	
	To the Hospital or Attantwithin 24 hours after deatl To tha Funaral Diractor: completely filled in by the	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the besidence in the property of t	s of examination and/or inv	occurred at the tin	ne, date and place, a pinion, death occurre	and due to the ca	use(s) and manner as te and place, and due	s stated. to the cause(s)
)	To the within Comp.	M	29b. Signature and title of certifier  30, Name and address of person who completed cause of	tuolly f death (Item 23a) (Type,	Print) 29c. License	8705		d. Date signed (Month	h, Day, Year)
	Sta Registr		Alan Carroll MD 31.  31. Date filed (MonDer Year) 8 2004 32. 1691	S. Seton strar's Signature	backs	Emmi	tsburg	Md	21727

			DA-A-	epartment of Health and No		iene 0 (	14 42482
	Physici	an.	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death
	/Medic		Rodney C. Fowler		Dec.	23, 20	04 10:20 a M
	Examir	ner	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		4c. County of	of Death e Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 M 2 F 50 50	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Yeer)	Birthplace (State or Foreign Country)
	Director		214-56-1783	15.	Jan. 4,	1954	MD
	ylanc how		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	e Ma	cto	MD Anne Arundel	Pasadena			1 ☐ Yes 2X No
	with th	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of W	hat Country?
	s 23e	eral	315 Early Pride Court  11. Marital Status 12. Was Decedent Ever in U.S.	21122			JSA
21215-0036	hours after death with the Maryland tural', or Items 23e or 28e-f show Examinations be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecity Yes or No- Rican, etc.)		- American Indian, s, White, etc. White
2-0	72 hours 'netural', dical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation	ina	16b. Kind of Bus	siness/Industry
21	C	nple	Elementary/Secondary (U-12)   College (1-40r5+)	(Give kind of work done during most of work life. DO NOT use retired)			
121	e filed withi Il Hygiene. other than vent, II.e M		2 17. Father's Name (First, Middle, Last)	Coffee Sales/General			Coffee Service
Maryland	e d la be	Be	Byron Fowler	18. Mother's Name Doris Me		Maiden Surname	)
7	2 should to and Ment is marked reumatic e	<sup>2</sup>	CONTRACTOR CONTRACTOR	Mailing Addrass (Street and Number or Run		City or Town 9	State Zin Code)
	1 and 2 s Health ar tem 27 is			15 Early Pride Court			
ore,	ges 1 and 2 should it of Health and Mer if item 27 is marke or other treumatic		20a. Method of Disposition 20b. Place of	Disposition (Name of	Date	20c. Location - C	City or Town, State
Ē	Page nent c		Tabular 2 Cremation 3 Chemoval from State	Dec.	28,	Glen Bu	rnie, MD
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licensee	Barranco & Sons, P. 495 Gov. Ritchie Hw	A. Sever	rna Park rna Park	Funeral Home
	æ		23a. Parti. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
1	Prysician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		resulting in death)  Due to ( as a consequence of	i):			
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Вох	death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date	
0.	0 0 0	ysici	1   Yes 2   No 4   Pregnant at time of death 9   Unknown	5 Other (specify)		Mont	h Day Year
α_	es that the de igned by the be detached	Ph.	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
ords,	law requires that the as been signed by th 2 should be detache	ted by			1 ☐ Yes	1.	Probably 4 Unknown
Il Record	The ate h page	Completed			24a. Was an autopsy perform	/ pri led? de	ere autopsy findings available or to completion of cause of ath?
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one	)	
of	S is	- To	1 ☐ Yes 2 No Prosper 2		ne 5 Resider		
Division	Attending Isr death. ector: After by the funer	cation	Natural 5 ☐ Pending (Month, Day Year) Inj 2 ☐ Accident investigation	Work?  M 1 Yes 2 No	28d. Describe hov	w injury occurred	
Σ	tal or Attend 's after death el Director: ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,		or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manr te and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	29c. License number	29	d. Date signed (	Month, Pay, Year)
			the the MD	055187		12/2	3/04
			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	tel M		Center
	Sta Registra	-	31. Date filed (Month, Day, Year) DEC 2 7 204 4 32. Resistrar's Signature	South		to to the ten the	

	_		1 - For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of I tificate of	lealth and Death		giene () L	42483
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	n. FENTO	5N			2. Date of Dea Month	Day Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Sex 15 15 15 15 15 15 15 15 15 15 15 15 15	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days			(Year) C	rthplace (State or Foreign ountry) NY
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	the Ma	ecto	MD Anne Art	undel		Severr	na Park		10g. Citizen of What C	1 ☐ Yes 2 No
	ath with the Marylan s 23a or 28a-f show	al Di	43 West McKinsey	Road, Apt 309	)		21146		USA	ounty :
960	or Ita	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	I2. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub I ☐ Yes 2 🔀 No		(Specify Yes or No- ento Rican, etc.)		
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Deced (Give life, L	lent's Usual Occu kind of work done DO NOT use retire Homen	during most of w	vorking	16b. Kind of Business	Mome
Maryland 2	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than "to other traumetic event, I're Mark	To Be Co	17. Father's Name (First, Middle, Last) Thomas Joseph Fla	ınagan			18. Mother's N	ame (First, Middle,		
	and 2 sho salth and I n 27 is ma er traume		19a. Informant's Name/Relationship (Ty) Andrew Fenton/Son	ре, Print)					r, City or Town, State, MD 21044	Zip Code)
Baltimore,	Pa ant ury		20a. Method of Disposition  1 XBurial 2 Cremation 3 R  4 Donation 5 Other (Specify)		lace of Dispos emetery, cren Vetera	sition (Name of natory or other pla ans cemet	ce) Dec	ember 23, 2004	20c. Location - City of Crownsvill	e, MD
Balt	permit. Pa Departmen Importent: any injury		21. Signature of Funeral Service Linanse	Tu-	22 B 4	Name and Addre arranco 95 Gov.	& Sons, Ritchie	P.A. Seve	erna Park E erna Park,	Funeral Home MD 21146
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	withii To th	×	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mont	
•			30_Name and address of person who con	moleted cause of death (Ita-	23a) /Tuna 1	D41	648		12-21-	4005
			STEPHEN CILDMIN			CONSE 1	Juny Ay	mak oor	12-21-	21401
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			for Amend 23a per 1 State Registrar AACO Health	Phy.State on dept. on h	f Maryland 12/23/04	d / Depa	artment rtificate	of H	ealth a Death	and M	lental Hy	giene	L L	248	L,
	Dhyois		1. Decedent's Name (First, Middle,								2. Date of Dea			3. Time of De	eath •
	Physic /Medi		Mark William Gar	rven Fish	er						Decemb		Year 2004	0402	М
1	Exami	ner	4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, 7	Fown, or	Location of	of Death		4c. Count	y of Death		
			Anne Arundel Me			4 to 1 - 4 - 1	Ann If Under	apo]		24 1140			Arun		
	Funeral Director		353–58–8709 Usual Residence of Decedent	3. Sex 1 <del>X</del> M 2 ☐ F	7. Age (In yrs. la 59	Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day May 21	, Year) , 1945	9. Birthpl Coun Eng	ace (State or F try) Land	oreign
	/land		10a. State 10b. County		10c. City,	, Town or Lo	cation						10	Od. Inside City I	Limits
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			30. Name and address of person wh	o completed cause	of death (Item 2	(Type, F	Print)	11.	), ,	0	Dr	DLO:	) 1	00	
	Sta Registr	4.75	31. Date filed (Month, Day, Year)  DEC 23	2004 32. F	gistrar's Signatur	y A	met	)	7 - 1-	7/1	(-/1)	11/16/	(1) !	1 12	

State of Maryland / Department of Health and Mental Hygiefje For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Dianna Elizabeth Frank December 28, 8:35 A M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 12608 St. Patrick's Road, S.E. Little Orleans Allegany If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/13/1954 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1□M 2⊠F 218-64-4736 50 Yrs. Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "neturel", or items 23a or 28e-f show or other treumatic event, the Medical Examiner must be indiffed at MD Allegany Little Orleans 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12608 St. Patrick's Road, S.E. 21766 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 →No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Importent: If item 27 Is marked of Michael Dorothy Marie Pau1 Monroe Knopp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12608 St. Patrick's Rd, SE., Little Orleans, MD 21766 Charles Lee Frank / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 12/29/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. eny in 404 Decatur Street, Cumberland, MD 21502 Cedams 23a, Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a co equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-Division of Vital Records. P.O. Box 68760. the attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? ō 5 Other (specify) 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ANO 3 Probably 4 Unknown 1 Yes has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe this certificate 2 🗆 No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: hin 24 hours after death. the Funerel Director: After 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier 0 December 28, 2004 D22181 completed of death (Item 23a) (Type, Print) Gary L. Wagoner M.D., 925 Bishop Walsh Drive, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 oaks 2004 Registrar

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Balt	permit. Departr Imports any inji		21. Signature 1 Runeral Service Sicens	Wade, Dire	ot of	Sta bal	të adadë: timore,	my Board MD 2120:		. Baltin	ore	Street
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		Completed		_					24a. Was auto perf 1 X Yes	psy ormed?	prior to death?	topsy findings available ompletion of cause of
of Vit	> 0 0	To Be	25. Was case referred to medical examiner?  1 XYes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/Ou	ıtpatienf	Other	26. Place of Death  4 ☐ Nursing Hon			ner (Spec	ify) AT SCENE
sion o	To the Hospital or Attending Ph within 24 hours attended. To the Funeral Director: After th To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur Found <sup>h, Day</sup> 12-19-04	Four 7:4	4 A		es 2 X No		how injury occur	<b></b>	
Divi	ital or At irs after o ral Direct led in by		4  Homicide determined	28e. Place of Inju- building, etc Scene	:. (Specify)			pa	TTIMOI	e, Ma		ral Route Number, rban Way
	the Hospital hin 24 hours a the Funeral I mpletely filled	Medical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best oner: On the basis of and manner sta	examination an	a, death oc d/or invest	curred at the time tigation, in my opi	e, date and place, a nion, death occurre	nd due to the ed at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
	To t To t Com	M	29b. Signafure and title of certifier				29c. License O.C.I			DEC. 19		
			30. Name and address of person who co	O, HD	111 PE			ALTIMORE,	MARYLA	ND 21201	L	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 1 2	32. Ragistra	r's Signature	Lo	soll !					
DHN	JH 17 Rev 1/20	001				0.	· · · · · · · · · · · · · · · · · · ·					

Registrar

6146-

		1 - State of M		artment of Health and M rtificate of Death		giene Reg. No. 0 0 4	42488
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Janice W. Gosne	11		2. Date of De Month	ath Day Year	3. Time of Death 4 2255 M
Exami		4a. Facility Name (If not institution, give street and number Memorial Hospital		4b. City, Town, or Location of Death Easton		Talbo	ath +
Funeral Director		5. Social Security Number 577-52-3881  Usual Residence of Decedent	Age (In yrs. last birthday) 66 Yrs.	Months Days Hours Min.	8. Date of Bir (Month, Da July 15	th y, Year) ,1938 Te	rthplace (State or Foreign Country) X a S
Maryland a-f show	ctor	MD Caroline	10c. City, Town or Lo	eston			10d. Inside City Limits 1 Yes 2 No
ath with the 23a or 28	Funeral Director	10e. Street and Number 4439 Bethlehem Road		10f. Zip Code 21655		10g. Citizen of What C United St	•
Gosnell, Janje W Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Ď.	11. Marital Status  1 Never Married 2 Married  3 XX Widowed 4 Divorced  12. Was Deceder Armed Force: 1 Yes, Give Year or Dates	No	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Maryland 21215-0036 Maryland 21215-0036 and 2 should be filed within 72 hours all the and Mental Hygiene.  Zi Is marked other than "naturel", or treumstic event, the Medical Exerti	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40	(Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)  try Farmer	ing	16b. Kind of Business Perdue P	oultry Co.
Jani Ce yland 21215 buld be filed within 72 Mental Hygiene. erked other than "ne erked other than "ne	To Be C	17. Father's Name (First, Middle, Last)  Denra Warner		Blanche	Hall	Maiden Sumame)	
re, Mary stand 2 shot the mark and the mark		19a. Informant's Name/Relationship (Type, Print)  Sharon L. Hayden/Daug	ghter P.O	ng Address (Street and Number or Rure Box 124, Pitt	SVille	er, City or Town, State,	Zip Code) 850
dosnell, dalimore, Maryl mair. Pages 1 and 2 should partment of Health and Me portant: If them 27 is mark yilyury or other treumstiin 28.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat  4 ☐ Donation 5 ☐ Other (Specify)	Eastern Sho	ore Vet. Cem. 12/30		20c. Location - City o	Maryland
Ball  permit Depar Impor		21. Signature of Funeral Service Licensee  Milharl 7. Elbarr	2	2. Name and Address of Facility $Fra$ 16 N. Main St.,	Feder	calsburg,	MD 21632
Physician /Medical		resulting in death)	I line. IINATED HIS	STICPASMUSIS	or respiratory ar	rest,	Approximate Interval Between Onset and Death
Examiner	Jer.	Sequentially list conditions b. PACYT	as a consequence of):  OPENIA  as a consequence of).				
8760, cate be executed physician and the burial-transit	dical Examiner	lady, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or a d.)	as a consequence of):				
Division of Vital Records, P.O. Box 6 or Attending Physicien: The law requires that the death certific after death.  Director: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as	by Physiclan/Me		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	olivery Day Year
cords, P	ted by P	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given in Part I.		obacco use contribute t res 2 □ No 3 □ P	o the cause of death? robably 4 Dunknown
al Recc The law r cate has be	Completed				24a. Was autop perfor 1  Yes	an 24b. Were a prior to death? 2 \( \begin{array}{c} \text{Arg of the prior to death?} \\ \text{2 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{2 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{2 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{2 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{2 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{2 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{2 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{3 \begin{array}{c} \text{4 \begin{array}{c} \text{Arg of the prior to death?} \\ \text{4 \begin{array}{c} 4 \b	utopsy findings available completion of cause of s 2 \( \sum \) No
on of Vital Reding Physicien: The the After this certificate he funeral director, page	on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1 No Pending  27. Manner of Death 1 Natural 5 Pending			me 5 Resid	ne) lence 6 □Other (Spe ow injury occurred	ocify)
Division or To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be	njury - At home, farm, streetc. (Specify)	M 1 □ Yes 2 □ No eet, factory, office	28f. Location (S City or Tow	Street and Number or R n, State)	ural Route Number,
Di the Hospitel or in 24 hours afte the Funerel Dir spletely filled in	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the besi and manner: On the basis and manner:	or examination and/or inv	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the co ad at the time, c	cause(s) and manner as date and place, and due	s stated.  to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier    June Police		29c. License number D0059487	-	12/26/09	th, Day, Year)
		30. Name and add/ess of person who completed cause of John Botsis, M.D. 21  31. Date filed (Month, Day, Year) 32. Regis		Print) ington St., Eas	ston, l	MD 21601	
Sta Regist			Silver's Signature	Correlies			

State of Maryland / Department of Health and Mental Hygien 42489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Mattie Lillian Goehringer 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ORCHESTER GENERAL "AMBRIDGE DORCHE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 95 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Year) 909 213-22-5132 1 □ M 2 T F Director Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f ehow ampingury or other traumatic event, the Madical Examinat must be notified at once. 10a State 10h. Counts 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Hurlock 1 ☐ Yes 2 TNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4825 Skinners Run Road 21643 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Bryan Anna Elizabeth Baynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Goehringer/ Son 4825 Skinners Run Rd., Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cem. 12/28/04 Preston, Maryland `4 Donation 5 Other (Specify)  $^{22.\,\,\text{Name and Address of Facility}}$  Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Mulail 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eumonin 24 hrs disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner certificate be executed burial-transit ON Due to (or as a on equence of): attending physicien for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the a ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð pe 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 245. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29c. License number 29b. Signature and title of certifier 30. Name and widre of person who completed cause of death (Item 23a) (Type, Print) neden MA hne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State BOOK! Registrar DEC 2 9 2004

			4 10	epartment of Health and N Dertificate of Death	Mental Hygien Reg. N	711116 676911
	Physici	an	Decedent's Name (First, Middle, Last)  Joseph Delbert Green		2. Date of Death Month D	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Egle Nursing Home	4b. City, Town, or Location of Death Lonaco		Ic. County of Death Allegany
	Funeral Director		5. Social Security Number 213-12-9214 6. Sex, 120 M 2 □ F 84 Yr	Months Days Hours Min.	8. Date of Birth (Month, Day, Year October 09, I	9. Birthplace (State or Foreign Country)
	D		Usual Residence of Decedent			
	e Maryla la-f shov	ctor	Maryland 10b. County 10c. City, Town of Allegany	Lonaconing		10d. Inside City Limits 1
	th with th	al Director	10e. Street and Number 7 Railroad Street	10f. Zip Code 21539	10g. C	Citizen of What Country? USA
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show appring yor other traumatic avent, the Medical Exam, are must be indiffied at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 ② Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ② Yes 2 □ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	within 72 hound. Ind. Ihan "natura Is Medical E	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NDT use retired) Textile	ing 16b.	Kind of Business/Industry  Labor
and 2	d be filed v ental Hygie ced other t c avent, II	Be	12 0  17. Father's Name (First, Middle, Last)  Orland Green		e (First, Middle, Maide Margaret	
Mary	nd 2 shoul tth and Me 27 Is mark traumati	ဥ	19a. Informant's Name/Relationship (Type, Print) Patricia Cole/Daughter	Mailing Address (Street and Number or Rure Rt. 5 Box 15, K	al Route Number, City eyser, West Virg	
Baltimore,	Pages 1 ar nent of Hea int: If item ? iry or other		1. Burial 2 □ Cremation 3 □ Removal from State cemetery,	isposition (Name of		Location - City or Town, State  LaVale, MD
Balti	permit, Departm Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Eichhorn-McKenzie Funeral I	Home 8 East Mai	in St., Lonaconing, Md. 21539
	Pnysician /Medical Examiner	er	23a. Fart1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any, leading to immediate cause. Enter Underlying	heart Failur		Approximate Interval Between Onset and Death A Heurs
58760,	ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of)  d.			
Division of Vital Records, P.O. Box (	Attanding Physician: The law requires that the death certific death codeath. sctoc: After this certificate has been signed by the attending, by the funeral director, page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the Diocheles mellitis. CO	ne underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death? 2 □ No 3 ☑ Probably 4 □Unknown
Reco	The law re-	Completed	Peripheral Vascular Disea Neuropathy. Deman	20 ·	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
/ita	cian: ertifica ector, (	Be	25. Was case referred to medical examiner?	0.11	(Check only one)	
on of	ing Physi	lon: To	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year) Inju	ne of 28c. Injury at work?	me 5 Residence 28d. Describe how inju	
Jivisio	I or Attandi after death. Diractor: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
_	Hospita 24 hours Funeral	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, or and manner stated.	leath occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cause(s	s) and manner as stated. Individual place, and due to the cause(s)
21	1	Me	29b. Signature and title of certifier  Signature Signature and title of certifier	29c. License number  29c. License number	n D	ate signed (Month, Day, Year) EC 28 2064
1	TIVA		30. Name and address of person who completed cause of death (Item 23a) (T)  S. L. Sandhir mp 48 Tarn Ter	Apouls	Marylan	0 21832
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 9 2004  32 Registrar's Signature	Sparks		

			1 - State Registrar	partment of Health and Mental I ertificate of Death	Reg. N. 2. 004 42491
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Lucy Elizabeth Howard	2. Date of Month Dece	mber 23, 2004 1044 P M
	Exami		4a. Fecility Name (If not institution, give street and number) Doctor's Community Hospital	4b. City, Town, or Location of Death  Lanham	4c. County of Death Prince George's
	Funeral Director		5. Social Security Number 578 56 0299 6. Sex 1 M 2 具 64 Yrs.	Months Days Hours Min. (Month	(Birth Day, Year)  9. Birthplace (State or Foreign Country)  20, 1940Washington, DC
	show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
	the Man 28a-f sh	ctor	MD Prince Georges Mt. Rain	nier	1 √ Yes 2 No
	ath with the Maryla 23e or 28a-f shov	Funeral Director	3111 Queens Chapel Road, #202	10f. Zip Code 20712	10g. Citizen of What Country? United States
980	72 hours after death with the Maryland neturel', or items 23e or 28e-f show drait Examble must be multified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li> <li>Yes 2√√ No Specify:</li> </ol>	r No- ) 14. Race - American Indian, Black, White, etc. Specify: Black
15-0	- 3 3	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
212	ed with ygiene ser the	Com	Elementary/Secondary (0-12)   College (1-4or 5+)   12th   2 years	Supervisor	H.E.W
land	id be fil ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last)  Albert Moody, Sr.	18. Mother's Name (First, Mic Nell Lewis	ddle, Maiden Sumame)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "eny injury or other treumatic event, the Me. anni plury or other treumatic event, the Me. anno 2010.	F	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural Route Nu 50th St., NE #21 Washi	mber, City or Town, State, Zip Code)
σ	ges 1 and 2 t of Health If item 27 or other tre		20a. Method of Disposition  1 Burial 2 Acremation 3 Removal from State  20b. Place of Disposition cemetery, companies to the companies of the	position (Name of Date rematory or other place)	20c. Location - City or Town, State
Baltimore,	permit, Pages Department of I Importent: If ite eny injury or of once.		'4 Denation 5 Other (Specify) Chamber	s Crematory $  12/30/200$ 22. Name and Address of Facility John T.	4 Riverdale,MD. Rhines Funeral Home
8	90 5 9			015 12th St., NE Washi	
	Physician /Medical			Note the mode of dying, such as cardiac or respirator	Interval Between
B	Examiner		Due to (or as a consequence of):  Sequentially list conditions		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
8760,	ate be executed hysician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):		
687	rtificate ng phys as the	Medic	d.		
.O. Box	The law requires that the death certific ite has been signed by the attending p. bage 2 should be detached for use as t	Physiclan/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year
ords, P.	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the		id tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
	stolen: The law re certificate has be irector, page 2 sho	Completed			utopsy prior to completion of cause of death?
Vital	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner? element of the sex miner? 1 ★ Yes 2 No Hospital: 1 Inpatient 2 ★ EPVOutpati	26. Place of Death Check on one of Document 3 DOA	l one) esidence 6 □Other (Specify)
	iding Physicien: th. : After this certifica funeral director, p	lon: T	27. Memor of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c, Injury at 28d. Descrit Work?	pe how injury occurred
Division	Atter	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sequilding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No  street, factory, office 28f. Location City or	n (Street and Number or Rural Route Number, Town, State)
Ω	To the Hospital or within 24 hours afte To the Funerel Director Completely filled in the Complet		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and due to t	he cause(s) and manner as stated
	I o the Hospital within 24 hours a To the Funerel C completely filled	Medical	(check only one)  22	nvestigation, in my opinion, death occurred at the tim  29c. License number	ne, date and place, and due to the cause(s)
	Col Wit	-	29b. Signature and title of certifier	O.C.M.E.	29d. Date signed (Month, Day, Year)  December 24, 2004
2	4)		30. Name and address of person who completed cause of death (Item 23a) (Type MM N N N N N N N N N N N N N N N N N N	o, <sub>Print)</sub> 11 Penn Street, Baltimor	
E	Sta Registr	_	31. Date filed (Month, Day, Year)  DEC 2 9 2004  Registrar's Signature		

State of Maryland / Department of Health and Mental Hygiene 42492 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 19,2004 EVELYN HUGGINS 7:50 Pm Dec /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Of Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 24, 1926 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign **Funeral** Davs Hours 1□ M 201 Months Virgin Isle 78 Director 580-06-0394 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or hems 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d Inside City Limits 1 AYes 2 □ No Funeral Director North Potomac MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 U.S.A. 11614 Pleasant Meadow Dr 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 No Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Virgin Island Elementary/Secondary (0-12) College (1-4or 5+) School Monitor School System 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olivia Phipps Francis Adolphus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11614 Pleasant Meadow Dr N.Potomac, MD20878 Peggy Meade- Daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/28/04 SilverSpring,MD Gate of Heaven 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Fuenral Home P.A. 21. anature of Funeral Service Ligense 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the dishese shock, or heart failur. e, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CHRONIC MYELOGENOUS LEUKEMIA Examiner Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 H Unknown Pulmunary Embolism À 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 🔀 No TI You 2LING Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 

AC Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 🗌 Inpatient 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DMatural 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral D

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 21, 2004 D0054566 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joppa Road #230 Towson, MD 21286 MD 1220 A E. Sunitea Bhogairee, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 27 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 4 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Physician Month Dey Dey 2004 Ruth Eileen Harris 11:45 pm /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wilson Health Care at Asbury Village Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛛 F Months Yrs 192-01-7066 Director 18, 1919 Pennsylvania Usuel Residence of Decedent pamit. Peges 1 and 2 should be filed within 72 hours aftar deeth with the Manylend Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ty⊡Yes 2□No Director Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 301 Russell Avenue 20877 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 24 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 White Completed by I 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Teacher Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chalmers Calhoun 2 Mabel Hand 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donald C. Harris/ Son 26 West Fairbranch Circle, The Woodlands, TX 77382 20e. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State Vira United Methodist 1 Burial 2 □ Cremation 3 □ Removal from State Dec 31 Lewistown, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 2004 Church Cemetery 22. Name and Address of Fecility
Francis J. Collins Funeral Home Inc
500 University Blvd, W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 6 Weeks Sepsis Examiner Due to (or es e consequence of): Examiner Cellulitis of Legs The law requires that the death certificete be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Chronic Renal Failure on Hemodialysis, ASCVD, 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed Anemia, Bilateral Above-Knee Amputations, 24a. Was en eutopsy performed? Peripheral Vascular Disease 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑Nursing Home 5☐ Residence 6 ☐ Other (Specify) P 1X Yes 2 No this 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affar 5 Pending investigation 1 X Naturel ours efter death. eral Director: Af filled in by tha fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours e To the Funeral D completely filled To the Hospital edicai 29a. Certifier Excertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D04115 December 20, 2004 ( Rehect 10 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) H. R obert Birschbach, M.D. 201 Russell Avenue, Gaithersburg, MD 20877 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State DEC 27 2004 Ryadian Registrar

DHMH 16 Rev 6/95

			1 - For Stete Registrer	State of	Marylar			of He		d Mental Hy	/giene	004	42494
П	Dhysis		1. Decedent's Name (First, Middl							2. Date of D	eath	1, 1, 1	3. Time of Death
1	Physic: /Medi		Robert Patric	k Hackney,	Sr.					Decemb	er 22,	2004	11:00A <sup>M</sup>
¥	Examir	ıer	4a. Facility Name (If not institution	n, give street and num	ber)		4b. City, To	own, or L	ocation of D			unty of Death	
			106 Moxey Circ	le			Secre	tary			Dor	cheste:	r
	Funeral		5. Social Security Number	6. Sex 7 1 🕅 M 2 🗆 F		last birthday)	If Under 1 Months [		If Under 24 I Hours N	Hrs. 8. Date of Bi	irth av. Year)	9. Birthr	place (State or Foreign
	Director		220-58-6629	1 May 1 2 2 3 1	50	O Yrs.				Apr. 2	4,1954	Wash	ington, DC
	land		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					Т.	10d. Inside City Limits
	Many feho	ō	Maryland Dorche	ostor									1 X Yes 2 No
4	the 128a	rec	10e. Street and Number	ester	Sec.	retary	10f. Zip C	ode			10a Citizon	of What Cour	
با	3a or	0	106 Moxey Circ	1e				564			rog. Oilizei	USA	nuy?
	deatl	Funeral Directo	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13. \			anic Origin?	' (Specify Yes or No Jerto Rican, etc.)	0- 14.	Race - Americ	can Indian.
9	after or ite		1 Never Married 2 Marr	ried 1 Yes 2	No XINo		_	_		uerto Rican, etc.)		Black, White,	etc.
ဋ္ဌ	72 hours after death with the Maryland neturel', or items 23a or 28a-f ehow disal Exantine roust be notified at	1 by	3 ☐ Widowed 4 🏌 Divorced	If Yes, Give Year or Dat	es:		1⊡Yes 2Ď	NO .	Specify:		Sp	ecity: Whi	ite
21215-0036	72 h	Completed	15. Deceden (Specify only highes	t's Education st grade completed)		16a. Deced	dent's Usual C	Occupation	on ina most of	working	16b. Kind o	of Business/Inc	dustry
121	vithin ne. hen	I du	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work of DO NOT use ity Gu				Food P	rocess	ina
7	Hygie Hygie ther t		10 17. Father's Name (First, Middle,	(act)		becar	- Gu				J		
au	od o	Be	Tale Talmadge H	•				18		Name (First, Middle			
$\geq$	hould d Me mark matic	P	19a. Informant's Name/Relations			10h Mailin	- Add (0			ryn Rita		_	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28a f ehow any injury or other treumatic event, the Medical Examination until be notified at angle.		Kathryn Hackney							Rural Route Numb			
ē,	Heal Heal tem 3		20a. Method of Disposition	/ Hother	20b. F	Place of Disposemetery, crem	sition (Name	LIC] of	re, se	cretary,		and 216 on - City or To	
9	ages ant of it: If i		1 XBurial 2 ☐ Cremation  4 ☐ Donation  5 ☐ Other (S)						1 12/	27/2004			
∄	nit. F artme orter injur		21. Signature of Frineral Service		Ja					27/2004			aryland
ã	permi Depa Impo any ir		Menand	1 30 Jan	ller	Ze	ller F	uner	al Ho	me, P. O.	Box 2	207	1601
		1	22a. Part1. Enter the disease, or	complications that cau	sed the deat	h. Do not ente	or the mode o	f dying, s	such as card	East New	Market rrest.	2 MD و:	21631 Approximate
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	/Medical		disease or condition resulting in death)	a Due o (or	as a consequ	75101	/						
	Examiner			b. ENHC.	F 501 V	E Ht	125	IA	TUR	E			
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	ransi	Examiner	triat initiated events	c CATY	MAC	My	455	A	VE O	O CUM	EE SU	IVE	
Ö,	e exe ian a urial-		resulting in death) Last	Due to (or	as a consequ	uence of):		1	HEDIZA	TIMIL	UPE		
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9	e as		IF FEMALE:						-		- 1		
Вох	death certific e attending p od for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetal	death 3	Ectopic pregn	nancy				Date of deliver	•
- 0	it the de by the a tached f	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnan 9☐Unknow	it at time of de	eath 5□	Other (specif	(y)				Month I	Day Year
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Vital Records,	The law requires that the tee has been signed by the page 2 should be detached.	Completed by	RICHT SINF	HAMI	WLEC	TOM	U Ens	e given ii 1 <i>D</i>	MAN	20	obacco use c ∕es 2 □ No		e cause of death?
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ĕ	has has ge 2 :	ם	1776111071	1017 107	711 0	10116	1411	VV-	>	24a. Was autop	sy /	prior to com	sy findings available npletion of cause of
		-	HE YWMS	of CE	CUI	N e	0/2	4/	04.	1 ☐ Yes	2 No	death? 1 ☐ Yes 2	2□ No
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o	Phys	7	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inp		ER/Outpatient 28b. Time of		Inuny of	4 Nursing	Home 5 Hesio			)
0	ding th. After funer	타	1 Natural 5 ☐ Pending 2 ☐ Accident investig	g (Month,	Day Year)	Injury		Injury at Work?	2 🗆 No	28d. Describe h	low injury occ	urrea	
DIVISION	Attending or death.	ertification:	3 ☐ Suicide 6 ☐ Could n	ot be	Injury - At ho	me, farm, stre			20110	28f. Location (S	Street and Nu	mber or Ruml	Pouto Number
	spitel or Att ours after de nerel Direct filled in by t	erti	4  Homicide determin	building,	etc. (Specify	)	o., rao.o.y, o.,			City or Tow	m, State)	noor or ridiar	rioute Number,
	spite hours nere y fille	<u>a</u>	29a. Certifier 1 Certifying	g Physician: To the be	st of my knov	vledge, death	occurred at th	ne time, c	date and place	ce, and due to the d	ause(s) and	manner as sta	nted.
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical E	xeminer: On the basi and manner	S UI GXAIIIIIIALI	ion and/or inve	estigation, in r	ny opinio	on, death occ	curred at the time, o	date and place	e, and due to f	the cause(s)
	To the Hospitel within 24 hours a To the Funerel I completely filled		29b. Signature and title of certifier	11.				cense nu			29d. Date sign	ned (Month, D	lay, Year)
	1		Somme	HINCO 1	AKCI,	MID	A	00	471	67	121	27/01	4
		- 1	30. Name and address of person w				,		<u> </u>		, •-/	/ /	•
			Silviu Ziscovici	i, M.D., 11	1400 Ro	ckvi11	e Pike	, Su	iite 5	11, Rocky	ille,	MD 208	352
ı	Stat Registra	~	DEC 2 8	2004	strar's Signat	иге	S.						

04-8274 B.K.S ANTHONY W. HUGHES

.110	NI W. F	100	For Stete Registrar	State of M	laryland		artment rtificate			nd Me	-	giene	1000	1.21.05
	Physici		1. Decedent's Name (First, Middle Anthony	e, Last)	W.	Hug	hes				. Date of Dea	ath Da		3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution 2717 LEWIS A		)		4b. City, To SUITI		ocation of D		JEC.	4c	County of Dea PRINCE	uth
	Funeral Director		5. Social Security Number 578 92 6488 Usual Residence of Decedent	6. Sex 7. A 1 <b>X</b> M 2 □ F	ge (In yrs. la	ast birthday) Yrs.	If Under 1 Months [		Under 24 Hours	Min.	Date of Birt (Month, Da Feb 16			thplace (State or Foreign ountry) shington DC
	ne Maryland 8a-f show olified at	Director	10a. State 10b. County  Maryland Prince		10c. City	, Town <i>o</i> r Lo Suit	land_							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the		10e. Street and Number 2717	Lewis Ave	#A		10f. Zip C	ode 0746				10g. Cit	izen of What C United	ountry? States
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: If item 27 is marked other than "naturel", or items 23a or 28a-f show injury or other treumatic event, the Modical Examinar must be notified at highly or other treumatic.	by Funerai	11. Marital Status  XX Never Married 2 Marr 3 Widowed 4 Divorced	If Voc Give	Ever in U.S	l:	Vas Deceder Yes, specify		anic Origin Mexican, P Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)		14. Race - Am Black, Whi	erican Indian,
Maryland 21215-0036	I within 72 ho iene. r than "natur the May cal	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or	5+)	16a. Deced (Give life. L	lent's Usual ( kind of work OO NOT use ter	Occupatio done durii retired)	n ing most of	f working			ind of Business Private	,
yland 2	2 should be filed n and Mental Hygis 18 marked other reumatic event, II	To Be C		hony Hughes	, Sr.					Marg		E11e	n Segar	
	as 1 and 2 sh of Health and i item 27 Is m r other treum		19a. Informant's Name/Relations Margaret E. Ko										r <i>Town, Stat</i> e, . ginia 2	'
Baltimore,	Pages 1 and the part of the pa		20a. Method of Disposition 1 ☐ Warial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		'	ace of Dispos metery, crem shingte							ocation - City or	Town, State Maryland
Baltii	permit. Pages Department of Importent: If it any Injury or o		21. Signature of Funeral Service  **May & Hedg	Licensee			. Name and A	Address o	f Facility_	ee F	uneral	Но	me,Inc.	6633 Old ryland 20735
8760,	Late be executed /Wedical /Wedical / was injuried franching the burial-transit	ical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter, Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. STO KE  Due to (or as  b. Due to (or as  c. Due to (or as  d.	ine.  / N } s a conseque s a conseque	PALATE ence of):							ES	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifics tie has been signed by the attending phage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3 🗌	Ectopic pregi Other (s <i>peci</i>					2	23d. Date of del Month	ivery Day Year
<u> </u>	w requires that been signed by should be deta	by	Part II. Other significant condition	ons contributing to death b	out not resul	lting in the un	derlying caus	se given ir	n Part I.		_	bacco u es 2(	_	o the cause of death?
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Division of Vital Records,	vttending Phys death. ctor: After this y the funeral di	Certification: To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death  1 Natural 5 Pendin investig  2 Accident investig  3 Suicide 6 Could referred to medical medical medical properties.	pation    2 23/1	y Year)	Property of the street of the	28c.	Other: Injury at Work? 1  Yes		ng Home 28d	Describe h	ence 6	HOUSE	AT SCENE  FIRE  ural Route Number,
Δ	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		4 Homicide determ	g Physicien: To the best	of my know	riedge, death	occurred at t	he time. d	date and pl	27	City or Town	n, State,	of SVITE	-AND, AVYCAND
	To the He within 24 To the Fu completely	Medical	(Check only one)  29b. Signature and title of certifier	and manner st	t examinatio	on and/or inv	estigation, in	cense nu	on, death o	occurred a	at the time, d	ate and	place, and due signed (Mont) 23, 2	to the cause(s)
11)	P3		30. Name and address of person	who completed cause of c		23a) (Type, F L PENN		Т, В	ALTIM	ORE,	MARYL	AND	21201	•
	Sta Registr		31 Date filed (Month Day Year)	2004 32/Hegistr	ar's Signaty	Solar Solar	W.							

			For State Registrar	State of Ma			nent of Ho cate of D			giene Reg. No.	004	42496
	ysicia		Decedent's Name (First, Middle, Last)     Ann Hinsche						2. Date of De Month Dec.	Day	Year 004	3. Time of Death 5:45 A
	ledic amin	100	4a. Fecility Name (If not institution, give st Golden Age Guest H	lome		Sy	kesvil			4c. C	ounty of Death	
Fun Dire			212-22-0072	M 0727 F	(In yrs. last birth		Inder 1 Year oths Days	Hours Min.	8. Date of Bird (Month, Da Nov • 3	y, Year)		ace (State or Foreign Try) ylvania
laryland	nd at	J.	Usuel Residence of Decedent  10a. State 10b. County  Marry 1 and Decedent		10c. City, Town		)				10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the N	the notifi	Director	Maryland Baltimore  10e. Street and Number  6407 Gilmore St.		Woodlaw	10	f. Zip Code				en of What Count	
partillior; Wall yield 4.12.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time X7 is marked other then *natural*, or Itams 23a or 28a-f show	Starrings mass	by Funerai		2. Was Decedent E Armed Forces? 1  ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		13. Was D	1207 Decedent of His specify Cubar es 2\sum No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14	ted Stat Race-America Black, White, e Specify: Whi	an Indian, etc.
within 72 horiene.	the Medical B	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+		Give kind o life. DO No	Usual Occupa of work done d OT use retired)	tion uring most of wor			of Business/Ind	
and 2 should be filed within alth and Mental Hygiene.	c event,	Be	17. Father's Name (First, Middle, Last) Paul Lasko					18. Mother's Nan Efrozina	ne (First, Middle,	Maiden S		Litter y
12 should and Me	raumati	2	19a. Informant's Name/Relationship (Typ	_				nd Number or Ru	ral Route Numbe	er, City or		Code)
Pages 1 and ent of Heattl	y or other t		Daniel Hinsche (so  20a. Method of Disposition  1 & Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)		20b. Place of I cemetery	Disposition , cremator)	(Name of or other place	lge Dr. 1 ery 12/2	Date	20c. Loca	21//1 ation - City or Ton	wn, State
permit. F Departm Importar	eny injui once.		21. Signature of Funeral Service Li	wer		22. Nan	ne and Addres	s of Facility	1	1		ry, P.A.
Physic Personned Exam Physician and Physicia	lical iner	al Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions of any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	the death. Do not e.  Sclerot.  consequence of a conseque	ic Ca	mode of dying	g such as cardiac	or respiratory a	W11111		Approximate Interval Between Onset and Death I year
BOX of an attending	ched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ႃSNo 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal death		pic pregnancy ar (specify)			23	d. Date of deliver Month	ry Day Year
requires that the signed by	should be detached	by	Part II. Other significant conditions con	tnbuting to death bu	t not resulting in	the underly	ring cause give	on in Part I.				e cause of death?
vicion: The law requestricate has been	C/I	Completed							24a. Was autor perfo		24b. Were autop prior to con death? 1 \sum Yes	psy findings available apletion of cause of 2 No
ysician ysician is certifi	funeral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2∑ No	ospital: 1  Inpatier	nt 2□ER/Out	patient 3[	DOA Othe	26. Place of Dea			☐Other (Specify	)
en g	e funeral	ation: T	27. Manner of Death 1	28a. Date of Injury (Month, Day		me of jury	28c. Injury Work	at ? ∕es 2 □ No	28d. Describe	how injury	occurred	
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After	completely filled in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.		m, street, fa	actory, office		28f. Location ( City or To	Street and wn, State)	Number or Rural	Route Number,
e Hospi 24 hour	oletely fill	edical	29a. Certifier (Check only one) (Check only one) (Check only one)		examination and							
Tott	comp	Σ	29b. Signature and true of certifier				29c. License D20806				signed (Month, I	Day, Year)
gen	)	8	30. Name and address of person who co Patrick Turnes, MD					, MD 217	84			
R	Sta egistr		31. Date filed (Month, Day, Year)	32. Regi <b>k</b> ra 2004 <b>El</b>	r's Signature	de la	arte	, /	7.1			

			1 - For Stete Registrer	State of	Maryland / E	epa Cer	artment of He rtificate of E	ealth and M Death	ental Hygie Reg.		42497
П	Physic	an	1. Decedent's Name (First, Min	ddle, Last)					2. Date of Death		3. Time of Death
	/Medi		JAMES	EDWARD	HOLDE	R	SR		DECEMBER	23,2004	12:40P M
	Examir	ner	4a. Facility Name (If not institu FREDERICK ME				4b. City, Town, or			4c. County of Death	
			5. Social Security Number	MORIAL HOSP			FREDERIC	CK If Under 24 Hrs.		FREDERIC	
ŀ	Funeral Director		225-40-0045	101M 2□F	7. Age (In yrs. last birt	rs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Dril 11.	1934 Mary	place (State or Foreign ntry) 1 and
	and w		Usual Residence of Decedent  10a. State 10b. Cour		10c. City, Town	orlo	antina				
	Aaryla f sho	ō								1	10d. Inside City Limits 1 XYes 2 □ No
	28e-	rect	MD Fred	lerick	Brunst	vic	10f. Zip Code		100	Citizen of Miles Co	
	3e or	i D	513 West Pot	-omno Stroot					Tog.	Citizen of What Cour	ntry ?
	death	Funeral Director	11. Marital Status	12. Was Deced	lent Ever in U.S.	13. V	21716 Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-	USA 14. Race - Americ	can Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-f show with injury or other traumatic event, the Medical Eventil or must be notified at ODGE.	/Fu	1 ☐ Never Married 2 🕅 M		2 □ No				Rican, etc.)	Black, White,	
8	urel',	d by	3 Widowed 4 Divord	Year or Dat	es: 1954 <b>-</b> 1957		Yes 2X No	Specify:		Specify: Whi	te
15	"nat	iete	15. Deced (Specify only high	lent's Education hest grade completed)	16a.	Give	lent's Usual Occupat kind of work done du DO NDT use retired)	tion uring most of workin	g 16b	. Kind of Business/In-	dustry
21215-0036	withi Bne. then	Completed	Elementary/Secondary (0-12	College (1-4	401 5+)		trician				
	illed Hygii other	Be C	17. Father's Name (First, Midd	le, Last)	ينا ا	EC		18. Mother's Name	(First, Middle, Maid	Railroad Hen Sumame)	
Maryland	should be ind Mental marked o	ToE	Henry James	Holder				Katie I	orean Nel	son	
lan	2 sho and I s ma		19a. Informant's Name/Relation		19b.	Mailin	g Address (Street ar	nd Number or Rural	Route Number, Cit	y or Town, State, Zip	Code)
	1 and tealth sm 27 ther tr		Mary P. Holo	ler - Wife	51	3 1	West Potor	mac Stree	t - Bruns	wick, MD	21716
וסר	Pages hent of Hunt: If ite		20a. Method of Disposition  1 Burial 2 Crematio 4 Donation 5 Other	n 3 Removal from Si		Dispos , <i>cren</i>	sition (Name of natory or other place)	) Da	ite 20c.	Location - City or To	wn, State
Baltimore,	permit. Page Department of Important: If eny injury or once.		' 4 □ Donation 5 □ Other  21. Signature of Funeral Service		Brownsvi	lle 	Heights Cem	1.   12/27	/2004 Br	ownsville	, MD
Ba	Depar Impo eny ir		18147	8-		22.	Name and Address	Eack	les-Spenc	er Funera	1 Home
			23a. Part1. Enter the disease,	or complications that causes on each	used the death. Do no	ot ente	or the mode of dying,	such as cardiac or	ers Ferry respiratory arrest.	, WV 2542	Approximate
	Physician		Immediate Cause (Final disease or condition			111	in dial	in An.	77 12		Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or	ras a consequence of	You	Constant	Dane	4167		
	Examiner	_	Secuentially list conditions	b. Ch	ence ale	st.	unt ve	lung de	seese		
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequence of	):		U			
	al-trai	Examiner	that initiated events resulting in death) Last	c	as a consequence of	):					380
68760,	tificate be executed g physician and as the burial-transit	edicai		d							
-		-	IE EEMALE:								
Вох	eath cert attending I for use	lan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		me of pregnancy h 2 Fetal death	3 🗆	Ectopic pregnancy			23d. Date of delive	
0	The law requires that the death cer ste has been signed by the attendir page 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of death m	5 🗆	Other (specify)			Month	Day Year
_	that hed by deta	by Ph	Part II. Other significant condi	itions contributing to dea	th but not resulting in	he un	derlying cause given	in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
Records,	w requires been sign should be	ed b	Peripheral	Vanicular i	disease				1 Yes	2□No 3□Proba	ably 4 Unknown
000	law re as bee 2 sho	Completed	Apertension	-					24a. Was an	24b. Were autop	osy findings available
Ĭ.		Com	N						autopsy performed?	prior to con death?	pletion of cause of
Vital	ilcien: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	al			2	26. Place of Death		10 105	26,140
ot \	Physicien: r this certific ral director,	2	1 ☐ Yes 2 ☐ No		patient 2 ER/Outp		3 DOA Other:	4 Nursing Home	e 5 ☐ Residence	6 □Other (Specify	)
ח	ling Afte	ion:	27. Manner of Death 1 □Natural 5 □ Pend	31119	Injury 28b. Tir Day Year) Inj		28c. Injury a Work?		d. Describe how in	ury occurred	
Division	ten deat tor: the	ficat	3 ☐ Suicide 6 ☐ Coul		Injury - At home, farn	n stre		s 2 No	f Location (Street	and Number or Rural	Pauta Mumbas
2	e Hospitel or At 124 hours after of E Funerel Directely filled in by	Certification:	4 Homicide deter	mined 200. Face of building	, etc. (Specify)	1, 5116	or, raciory, office	20	City or Town, Sta	te)	Houte Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in		29a. Certifier 1 Certify (Check only 2 Medice	ring Physicien: To the be	est of my knowledge,	death	occurred at the time,	date and place, an	d due to the cause(	s) and manner as sta	ited.
	the H in 24 the F nplete	Medical	one)	and manner	5 Of examination and/	or inve	estigation, in my opin	ion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	With Con	Σ	29b. Signature and title of certif	four mi	>-		29c. License n			ate signed (Month, D	
	X		20.11	// /	-1 -1 -1		MDD005	4636	De	cember 24	, 2004
1	.)		30. Name and address of perso					п 1	VD 04=	0.4	
	s Sta	te	Fyed W. Hague 31. Date filed (Month, 1947, Pea	2 7 2004 32. Red	strar's Signature	re_	Avenue -	rrederic	k, MD 217	01	
	Registra	ar i			aller St	and the same	Mark o				

			1 - For State Registrar			nd / Depa		Health and I	Mental Hygi		4 42498		
	Physic	ian	Decedent's Name (First, M	iddle, Last)	t)				2. Date of Death Month	Day Ye	3. Time of Death		
	/Medi	cal	MAURERN	A -				PKINS	DECEMBER	51 500	4 4:4 HM		
ir.	Exami	ner	4a. Facility Name (If not institu			<i>r</i>		or Location of Deatl	1	4c. County of [	eath		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	M 0 /2 € If Under 24 Hrs.	8. Date of Birth		Pirthalogo (State of Familia		
	Director		215-78-6069	1 ☐ M 2 🔀 F	42	Yrs.	Months Days		(Month, Day,		Birthplace (State or Foreign Country)		
	P .		Usual Residence of Deceden						Feb. 19,	1962	Maryland		
	e Marylar la-fahow liffed el		Maryland An	ne Arundel	10c. Cit	y, Town or Lo		polis			10d. Inside City Limits  12€ Yes 2 □ No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ahow any injury or other traumatic event. Ite Medical Examiner, usibe notified at ance.		10e. Street and Number 112 Roselawn Road				10f. Zip Code	21403	g. Citizen of What Country? U.S.A.				
	r dea		11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.	.S. 13.	Was Decedent of	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No-	14. Race - A	merican Indian,		
36	or It		1 Never Married 2 1	Married 1 ☐ Yes If Yes, Gi	1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates:  ucation de completed)  16a. [		1 ☐ Yes 21 <b>X</b> No		o riloan, etc.)	Specify: V	/hite, etc. /hite		
Ö	hours tural		3 ☐ Widowed 4 € Divor				Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						
15	in 72		(Specify only hig	dent's Education phest grade completed)						16b. Kind of Business/Industry			
21215-0036	with iene.		Elementary/Secondary (0-1 12	2) College (	1-4or 5+)		Revenue Specialist Supervisor				State of Maryland		
	i Hyg other		17. Father's Name (First, Mide	dle, Last)			<u>-</u>		ne (First, Middle, Ma		- Isal y Laria		
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, It e M.		Alfred Hopki	ns					n Mrlik				
lary	2 should and Ment is marked aumatic e		19a. Informant's Name/Relati			19b. Mailin	g Address (Street	and Number or Ru	ral Route Number, (	City or Town, Stat	e, Zip Code)		
	1 and 2 Health tem 27 i		Barbara Hopk	ins/sister					polis, Ma	ryland	21403		
Baltimore,	of He		20a. Method of Disposition 1XXBurial 2 ☐ Crematic	on 3 Removal from	State 20b. P	tace of Dispo emetery, cren	sition (Name of natory or other pla	ice)	Date 20	c. Location - City	or Town, State		
Ĕ	permit. Pages Department of I Important: If its any injury or o once.		`4 □Donation 5 □Othe						9/2004 A	nnapolis	, Maryland		
3all	permit. Departn Imports any inju		21. Signature of Funeral Serv	ice Licensee	111				n M. Tayl				
_	0.0 E 6 0		23a. Part1. Enter the disease	E, W	Willi					-	, MD 21401		
À	Pnysician /Medical Examiner	ed by Physician/Medical Examiner	shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Converted to the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause on a distribution of the cause of the	a. Constand Death  The to (or as a consequence of):  And Constand Death  And Constand Death  And Constand Death  And Constand Death  And Constand Death  And Constand Death  And Constand Death								
.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-fransit		resulting in death) Last	c	(or as a c <i>o</i> nsequ	uence of):							
	at the death certifica by the attending phatached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23d. Date of delivery Month Day Year			
rds, P.	quires tha n signed I uld be det								co use contribute to the cause of death?				
00	aw requir s been s 2 should	lete							24b. Were autopsy findings available				
<u> </u>	the ate h page	Medical Certification; To Be Completed	OF Management to an extension to an extension to						autopsy performe 1 Tes 2	prior t	o completion of cause of		
5			25. Was case referred to med examiner?  1 Yes 2 No	Magaital: 1	Hospital: 1 Place of Death (Check only of Documents) Other: 4 December 4 Dece								
	ding After fune		27. Manner of Death	28a. Date	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work?								
Division	Nospital or Attendi 24 hours after death. Euneral Director: A stely filled in by the fu		3 ☐ Suicide 6 ☐ Cou	ld not be prmined 28e. Place building	be one state of laws Athers to the state of					at and Number or State)	Rural Route Number,		
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by		29a. Certifier (Check only one) Certifier 2 Medic	ying Physician: To the al Examiner: On the ba and mans	asis of examinati	vledge, death ion and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, death occur	and due to the caus ed at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)		
	To the within 2 To the complet		29b. Signature and title of cert	fier			29c. Licens	e number	29d.	Date signed (Mo	nth, Day, Year)		
			1 Oxahi	2 MD			RES	-000	De	C 40 0 C -	21,2004		
			30. Name and address of pers		e of death (Item	23a) (Type, F							
_			KHAN W. LI	, 4940 8	CASTERN	AVEN	1UE, B	ALTIMOR	2E, MD	21224			
N	Sta Registr	3	31. Date filed (Month, Day, Ye	2 3 2004	instrar's Signati	Ure	met						

Physic		1. Depedent's Name (First, Middle, Last) LINDA HAHMER	2. Date Mor					
/Medi Examir		4a. Facility Name (If not institution, give street and number)  CHLake	4b. City, Town, or Location of Death Sall Sbury	4c. County of Death Wi comic				
uneral irector		5. Social Security Number  6. Sex 1 M 2 M F  7. Age (In yrs. last birthday 1 M 2 M F  7. Usual Residence of Decedent	Months Days Hours Min /Mon	e of Birth nth, Day, Year) 9 Birthplace (State or Fo Country) MARYLAND				
show	ō	10a. State 10b. County 10c. City, Town or L	ocation ONSBURG	10d. Inside City L 1				
or 28a-f show	irect	MD WICOMICO PARSO  10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?				
*naturel', or Items 23a	alD	32855 WILLOMET COURT	21849	USA				
	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	s or No- atc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE				
	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry				
other t	e Co	17. Father's Name (First, Middle, Last)	JTICIAN  18. Mother's Name (First, I	COSMETOLOGY  Middle, Maiden Sumame)				
rages I are a should be man in an of Health and Mental Hygiene. Int: If item 27 Is marked other then try or other treumetic event, I ha Man in a contract of the man in a c	To B	CHARLES WILLIAM HAMMER	DOROTHY	LOUISE JUMP				
		MICHAEL WHITE- HUSBAND 32855		Number, City or Town, State, Zip Code) ONSBURG, MD 21849				
		TERBUINI 2 CIGINATION 3 Memoval from State	ematory or other place)	20c. Location - City or Town, State				
Importent: I eny injury o once.		SPRINGHILL MEMORY GA. 12/28/2004 HEBRON, MARYLAND  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  BOUNDS FUNERAL HOME  705 E MAIN STREET SALISBURY, MD 21804						
/sician ledical		23a. Pan. Enter the disease or complications that caused the death. Do not en shock, or heart failure, dist only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	iter the mode of dying, such as cardiac or respira					
rs after death.  ral Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner							
	Physician/Mec		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year				
	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e	e. Did tobacco use contribute to the cause of death  Yes 2 □ No 3 □ Probably 4 □Unkr				
	Completed	25. Was case referred to medical	1	. Was an autopsy findings avair prior to completion of cause death?  Yes 2 No 1 Yes 2 No				
	atlon: To Be	Was case referred to medical paraminer?  1						
	Certification:							
- 6 6		29a. Certifier Cartifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place, and due to prestination, in my opinion, death occurred at the	to the cause(s) and manner as stated.  time, date and place, and due to the cause(s)				
Funeral Directly filled in by	edical	(Check only 2 Madical Examiner: On the basis of examination and/or in one)  and manner stated.						
Dire Dire		Check only 2 Madical Examiner: On the basis of examination and/or in	29c. License number	29d. Date signed (Month, Dey, Year)				

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i> a	artment of H			giene	)4	425	00								
	Physic	an	1. Decedent's Name (First, Middle, Last	,				2. Date of De	ath Day	Year	3. Time of	Death								
	/Medi				rd Hall, J			Decembe	er 31 20	004"	0800	АМ								
	Examir	ner	4a. Facility Name (If not institution, give Union Hospital	street and number)		4b. City, Town, or		th		4c. County of Death										
	Funeral		5. Social Security Number 6. Se	x 7. Aq	e (In yrs. last birthday)	Elkton	I If Under 24 Hr	S. R Date of Bird	Cec		lana (Ctata									
м	Funeral Director			XM 2□F 8		Months Days	Hours Mir		у, <sub>Year)</sub> 1924	Coun	lace (State or stry) cyland	roreign								
	pu ,	1	Usual Residence of Decedent  10a. State 10b. County		140 O. T				, -/-	1101	Juliu									
	laryla shov	5	Maryland Cecil		10c. City, Town or Lo	cation				1	0d. Inside City 1 ☐ Yes									
	tha N 28a-f	Director	10e. Street and Number		EIRLOII	10f. Zip Code			10- 04	14/1 1 0		2 LA[140								
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Menlat Hygiene. If tiem 27 is marked other then "neturel", or items 23a or 28a-f show or other treumatic event, ITs Madical Examinar must be notified at	0	55 Hollis Circle			21921			10g. Citizen of											
		Funeral		12. Was Decedent Amped Forces?	Everin U.S., 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (	Specify Yes or No	Unite	e - Americ										
9		/Fu	1 Never Married 2 Married	Armed Forces?  1 Nes 2 N If Yes, Give Year or Dates:	World War TT	fYes, specify Cuba 1□Yes 2□XNo	in, Mexican, Pue Specify:	rto Rican, etc.)		ck, White,	etc.									
8		ed by							Specif	Whi	ite									
15		olete	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	orking	16b. Kind of B	usiness/Inc	lustry									
212	d with giene. ir ther	To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	rpenter	,		Cons	struct	ion									
פו	al Hyg		17. Father's Name (First, Middle, Last)			•	18. Mother's Na	me (First, Middle,			22011									
yla	1 and Health em 27 ther tu		Herbert R. Hall,					a Gertrud												
Maryland 21215-0036			19a. Informant's Name/Relationship (Ty			g Address (Street a					Code)									
			Herbert R. Hall,	Jr./Self	20b. Place of Dispo	ollis Cir	cle, Ell	cton, Mar	yland 2 20c. Location -		um Stata									
Baltimore,	Pages nent of I ant: If its ary or o		1 X Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Delaware	vererans		ary 5,												
ij	- 5 F E		21. Signature of Funeral Service License	90 )	Memorial	Cemetery Name and Addres LCKS Home	2005 is of Facility	)	Bear,	Dela	ware									
ã	Departing Important in		Done is 8	Hub						lonul o	nd 210	121								
	cate be executed /Medical Examiner the burial-transit	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  103 W. Stockton Street, Elkton, Mary land 21021  Approximate Interval Between																	
			Immediate Cause (Final disease or condition		RESPIRATO	2y FAI	LVE				Onset and De	eath								
			resulting in death)		a consequence of):							·								
			Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							- 1	INKNON	ſΥ								
1			Cause (Disease or injury that initiated events																	
ó			resulting in death) Last  Due to (or as a consequence of):																	
68760,	cate be physici the bu	dlcal																		
		Physician/Med	IF FEMALE:	20 If you outnown	4.0000000000000000000000000000000000000				1											
Вох	Attending Physicien: The law requires that the death certific rideath in death certific death sector. After this certificate has been signed by the attending pector. After this certificate has been signed by the funeral director, page 2 should be detached for use as		in the past 12 months?	3c. If yes, outcome of 1☐Live birth 4☐Pregnant at	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of deliver	y Day Ye	ar								
Ö		nysie	1 Yes 2 No 9 Unknown 9 Unknown																	
σ.		ertification; To Be Completed by PI									Part II. Dther significant conditions cor	tributing to death bu	t not resulting in the un	derlying cause give	n in Part I.	23e. Did to	bacco use contr	ribute to the	e cause of dea	ath?
ord			. AGRIC STEMSIS 1 Yes . MYOCHEMPL INFARCTION 24a. Was an autopsy						es 2□No	2 No 3 Probably 4 ☐Unknown										
Records,										24b. Were autopsy findings available prior to completion of cause of										
_			· ATRIKE	ABRILLA-	Non			perfor	med?	leath? □ Yes 2		50 07								
Vital			25. Was case referred to medical examiner?	ospital:		Othe	_	ath (Check only on												
of			1 SInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Resider																	
ion			1 ⊠Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No																	
Division	spital or Atten ours after deat eral Director: filled in by the	tifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, stre	et, factory, office		28f. Location (St	reet and Number	er or Rural	Route Numbe	эr,								
	ital or A rs after al Dire led in by	O																		
	는 보고 하는 기계	edical	29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of er: On the basis of and manner stat	f my knowledge, death examination and/or inv ed.	occurred at the time estigation, in my opi	e, date and place inion, death occu	, and due to the carred at the time, d	ause(s) and mai ate and place, a	nner as sta ind due to t	ted. he cause(s)									
4	To the Hos within 24 hi To the Fun completely	Me	29b. Signature and atle of certifier			29c. License	number	2	9d. Date signed	(Month, D	ay, Year)									
}			1 Caulain	m.D.		D	005839	12	DECEMBE	1231	, 2004									
	6+1		30. Name and address of person who co	mpleted cause of de		rint)														
				GAUTAM 338 Pagistra		HT AZOH	ELK.	M, MOT	D 2193	1										
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 1 1 200	5 Sineur	r's Signature	de														